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The National Association for Mental Health, Inc.

The Voluntary Promotional Agency of the

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Founded by Clifford W. Beers

OBJECTIVES

The National Association for Mental Health is a voluntary organization working for the promotion of mental health; for the prevention of mental and nervous disorders; for the improved care and treatment of the mentally ill; and for the special training and supervision of the mentally deficient.

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MENTAL HYGIENE aims to bring dependable information to every one whose interest or whose work brings him into contact with mental problems. Writers of authority present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public are republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology are presented and discussed in as nontechnical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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THE EMPLOYMENT OF TEEN-AGE YOUTH AND MALADJUSTMENTS OF THE CURRICULUM

SECRETARY Tobin, of the United States Department of Labor, has recently issued a "National Policy on the Employment of School Age Youth." A high point in that policy is that the education of youth is our first responsibility. Good vocational choice and preparation and good working conditions are other essentials in this policy. While the policy as a whole is pertinent to mental health, the second recommendation is of special interest. It reads: "Encourage schools to adjust their curriculum and services to meet more adequately the needs of young people."

Nothing is more conducive to premature transition from school to work than a school experience that offers no challenge, and no group is denied that challenge more than the mentally retarded and deficient. No group, on the other hand, can draw less on their own resources to compensate for curricular deficiencies, because their resources are so limited. It is the mentally deficient who first lose the challenge for education. It is they who are first thrown on the labor market. It is they who have the narrowest range of vocational prospects, and the least preparation within that range. It is they who are most apt to fail and be started thereby on a career of short-term jobs when they more than others need stability. It is they for whom industry, following the pattern of the schools, finds it hard to make adjustments. It is they for whom no over-all official planning is made.

Each national, state, and local authority—health, welfare, education, mental health, labor, vocational school, and correction—each of these is concerned with the mentally deficient,

but each keeps its concern to itself, plans by itself, executes the plan by itself, and does not see that the success of its endeavor is dependent upon the work of the others. Joint planning and dividing a joint labor is the rare exception. It is significant that concurrently the national educational authorities are studying the preparation of teachers for exceptional children. Let us hope that these heads come together before they have to be brought together.

THE RÔLE OF GROUP THERAPY IN PREVENTIVE PSYCHIATRY *

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IN mental hygiene it is a common experience that just those individuals in the community whose mental health is in a most precarious condition are likely to deny their need for help and to refuse whatever counsel may come their way. There are not enough trained workers in the field of mental hygiene to overcome this resistance, nor are there enough to attend to the mental-hygiene needs of the individual citizen to-day. If we could enlist large numbers of people who are in close daily contact with the needy individuals—people who may not be professionally trained, but who could accept the principles of preventive mental hygiene—our work would become more forceful and effective. These are some of the reasons why modern mental-hygiene activities are focusing on groups rather than on individuals.

Until recently, group work was based on ancient methods and traditions and only very slowly has it evolved as a science. In this scientific development, group psychotherapy can offer new approaches to mental hygiene.

Group psychotherapy plays a significant part in the present development of preventive psychiatric group work. Its rôle, which we shall discuss in the following pages, is a double one. Emerging out of psycho-hygienic group needs and then developing into a therapeutic method, the group-therapy movement has resumed to a steadily increasing degree its original purpose: out of the therapeutic work, new and very effective methods have evolved for promoting the mental hygiene of groups and their members. This interesting double play is

* Read in part at the session on "Group Methods in the Prevention and Treatment of Mental Disorders" of the Fourth International Congress on Mental Health, Mexico City, December 17, 1951. A comprehensive bibliography of publications relating to the subject of this paper can be obtained from the author on request.

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of great practical importance for the worker in the field, as the following report intends to show.

History and Ancient Roots of Inspirational Group Work in Mental Hygiene.—Let us first examine how group therapy, one of the growing therapeutic forces in psychiatry, has its roots in the mental-hygiene movement. At the start of this century, the health condition of the poor and indigent began to reach the foreground of public concern in North America and group therapy was one of the answers to the problem of caring for the many who needed help.

To Dr. J. H. Pratt, of Boston, goes credit for the first scientific attempt to treat with group therapy patients suffering from physical illness. In his Boston Dispensary, Pratt formed a group of tubercular charity patients whom public sanitariums could not accommodate. With this group Dr. Pratt started in 1905 a type of treatment that he labeled "the class method." The initial purpose of the project was to cut down on waiting lists by attending to a large number of patients at the same time. This was started as a typical community project, attacking a public-health problem. It was organized with the help of facilities provided by the community resources of the Emmanuel Church and the Massachusetts General Hospital.

It was only in his second report on this experiment that Pratt noted far more important gains than those of a time-saving device. The treatment consisted of lectures and group discussions under Pratt's leadership. Tuberculosis was discussed—hygienic and preventive measures and therapy. Through discussions of their illness and the problems arising from it, patients found encouragement and a source of support and satisfaction in group participation. A competitive situation developed among the patients, who rivaled with one another for the speediest improvement and recovery. It was the emotional effect of the group upon the individual to which Pratt attributed a large degree of the success his new method attained.

Pratt and his co-workers then began to apply group therapy in their clinics with patients suffering from other types of chronic disease. Diabetic patients have been treated successfully, as well as patients with chronic heart disease and hypertension. The competitive factor in this type of group

treatment was used by Emerson to induce a group of mothers to achieve weight gains in their undernourished children.

Hygienic instruction through inspirational and suggestive techniques is, of course, an ancient practice which has played a paramount rôle in pre-scientific medical history. In our time, the performance of miracle cures and acts of faith are still fundamental to many sects. Numerous contemporary movements use suggestive-inspirational methods in dealing with physical or emotional health problems, like the Oriental Mazdasnan or the American Christian Scientists. The very popular American group movement, Alcoholics Anonymous, is a direct relation of these historic ritualistic methods. Eighteenth-century Mesmerism has been practiced in one form or another over the last 200 years and has been an inspiration to modern science through group applications of *"magnétisme animal"* and the *"baguet moral."* A detailed historic account of the magic practices in group therapy can be found in that fascinating book, *Adventures of the Mind,* by the medical historian, Arturo Castiglioni.

Influence of Psychoanalysis on Present-Day Group Work in Preventive and Therapeutic Psychiatry.—Anthropology and social psychology—in particular the work of LeBon, Frazer, and McDougall on the origins and growth of human society—have strongly influenced the development of group management in our time. Sigmund Freud's contribution to social psychology in *Totem und Tabu* and *Massen Psychologie und Ich Analyse* are basic treatises for psychoanalytically oriented group work. Freud's ideas on group psychology, which his followers developed further, have inaugurated a new approach, the analysis of groups. Likewise, deep-reaching changes in the dealings with groups have been effected in the teaching techniques of modern mental hygiene.

Through educational means, through propaganda, and through the principles of mass psychology, these findings have been incorporated into the structure of a progressive mental-hygiene movement. A new approach has taken its place in the historic heritage of preventive and therapeutic methods in psychiatry. This approach, the psychoanalytic, stands in counterpoint to didactic inspirational methods. Instead of repressing or denying man's primitive drives, the aim here is to harness their energy as constructive, vital, and con-

trollable forces, so that the individual may attain the fullest personal freedom and happiness within the framework of his social group.

Between the opposite poles in the practice of group therapy —the repressive-inspirational and the psychoanalytically oriented methods—there is a wide range of combination techniques, leaning more to one side or to the other, borrowing from both and including some original ideas by various authors.

Clinics whose approach is derived from Pratt have continued to develop repressive-inspirational methods aimed at removing symptoms rather than their causes. Some are rigidly organized and exercise authoritative leadership over their members. In the United States, Alcoholics Anonymous, Inc., and Recovery, Inc., are their most important representatives. Lazell and his followers, especially Klapman, the founder of the "Resurgence Movement," stand on a psychoanalytic premise, but use didactic classroom methods. Paul Schilder and Louis Wender were the first to do psychoanalytic group therapy. The approaches of Slavson, A. Wolf, Redl, and Foulkes are closest to the principles of psychoanalysis, but each of these authors has developed distinctly different techniques.

The theoretic groundwork has been published and forms an important part of the literature in this field. Redl's and Slavson's work with children and adolescents has begun to exercise considerable influence on practical mental-hygiene methods applied in child guidance, in progressive schools, in children's institutions and reformatories in the United States.

Bion has derived new and original concepts of group function and interaction which show their impact on English thinking. His work started during the war, when mass methods had to be found for the mental-hygiene needs of servicemen. Similarly, the U. S. Veterans Administration for the past several years has been developing, in an extended research project, new psychiatric group techniques for preventive and therapeutic work.

Other methods in the spectrum of group psychotherapy are difficult to classify because they deny psychoanalysis, while actually showing a great deal of agreement with psychoanalytic premises. Among them we can name Rogers' non-

directive method, which discards verbal interpretation entirely, but nevertheless uses psychoanalytic concepts in the approach to personality and behavior disorders. Interesting results have been achieved in mental-hygiene work (counseling) with college-student groups.

Through a very different approach, "acting-out" techniques, developed by Moreno *et al.*, bring the patient directly into a situation of dramatized interpretation. Lauretta Bender and A. Woltmann have adapted the "acting-out" technique to the use of puppet shows in group therapy with children. Similar methods have been used in child guidance in France and South America.

In the course of experience with these numerous methods, we will learn to recognize which type of individual can benefit most from one form of group therapy and which will need another approach. The large variety of methods available offers increasing opportunities for the choice of specific techniques for groups of different structures (age, social standards, basic problems, etc.). Only through trials and through the understanding of our errors can we arrive at the greatly needed standardization in applying psycho-hygienic group work.

Group Work with Chronic Patients, Convalescents, and Relatives of Patients.—Mental-hygiene projects emerge out of group therapy most frequently when treatment is concerned with a type of patient who is not too ill to participate actively in life. This is the convalescent who is ready to return home or the patient who can maintain contact with his surroundings, home, family, and community. It was with patients who had been able to remain in the home that Pratt formed his therapeutic groups, which became known as "thought-control clinics."

"Thought control" is a treatment method consisting of an elaborate ritual which is repeated at weekly meetings of a group consisting of from 15 to 40 patients. The session opens with a roll call. Patients are assigned to seats in accordance with a merit plan, which places the old-timers, "veterans" of the clinic, on honor seats in front and the newcomers in the back, from whence they have to work their way forward. Advancement in the seating arrangement is gained through

regular attendance and "good conduct," meaning improvement.

In another part of the program patients read to the group reports on the week's achievements—how their symptoms have been controlled, what progress they made in social participation, and so on. New members learn about the success achieved by others. Each newcomer is placed under the guardianship of a veteran member. In addition to the reading of the progress reports, a period of relaxation exercises, a brief lecture on emotional problems given by the leader of the group, readings of inspirational poetry, and a discussion in which newcomers are informed and encouraged by the leader, make up the program of a thought-control meeting.

Pratt reports that 36 per cent of the patients from the medical clinic were referred to thought-control clinics. Of these, 55 per cent follow through with the treatment, and 68 per cent of the membership show improvement. This is a fine achievement record for psycho-hygienic methods. Observers agree that an important factor in this success story is the personality of Dr. Pratt and of his selected co-workers. Identification with and dependence upon the leader, who represents a "good father," are the primary dynamic mechanisms that make the group process effective. In the secure atmosphere that this mechanism establishes, the members are able to develop friendly relationships among themselves; suggestions are accepted and followed due to the strong rapport with the leader-father.

Numerous similar methods are in use. In Chicago, Dr. Abraham Low has founded a club whose membership consists of former inmates from mental institutions and some neurotic patients. The club is named "Recovery." It has a house organ of its own (formerly *Lost and Found,* now *Recovery Journal*) which stresses the principles of self-help, and rallies the readers for self-defense against stigmatization of the mentally ill. Pamphlets on such topics as fear of heredity in mental illness, "sleep sabotage," handling of the mentally ill by their relatives, and so on are inexpensively and widely distributed.

The members of this organization also conform to a strict ritual. Patients who "sabotage" their recovery are rebuked;

patients who show improvement are rewarded. Great stress is put on the rules of the "recovery language," which interdicts the use of "temperamental lingo," such phrases as "uncontrollable headaches" or "terrible palpitations." "Sabotage" is one of the keywords in the recovery language. "Authority," meaning the authority of the leader-physician, also has vital meaning. Authority of the group leader is delegated to veteran patients with good records who are put in charge of group meetings held as often as three times a week.

Another large group of this type is Alcoholics Anonymous. Alcoholism is regarded by this group as a chronic disease, an incurable allergy to liquor. Its victims can be helped only by total abstinence. A member of this organization must pledge himself to abstain completely. When he relapses and seeks help, another member of Alcoholics Anonymous, himself a former alcohol addict, will be assigned to watch over him, to escort him unobtrusively wherever he goes to prevent his stepping into a tavern or liquor store.

Medical treatment and means of spiritual rehabilitation are offered to the alcoholic until he is sufficiently recovered to pick up the threads of his home, social, and professional life. Members have to attend frequent regular gatherings conducted in the form of revival meetings at which reports are given by anonymous participants about their fight against and victory over the addiction. A twelve-point "Program of Recovery," representing the group's articles of faith, and a series of prescriptions for "spiritual awakening" are closely related to the methods of Christian Science and those of the Salvation Army. With the latter, Alcoholics Anonymous is working in close coöperation, although its principles are interdenominational.

Considerable progress in this type of treatment has been made by Dr. Joshua Bierer and his collaborators, who founded a chain of "therapeutic social clubs" in London on the premises of "individual psychology." While the general tendency is still repressive, the value of spontaneous expression is strongly recognized, and the individual clubs enjoy a considerable amount of self-government. These clubs have become part of follow-up programs for patients released from mental hospitals. They are closely related to similar clubs maintained by a large number of these institutions in the

United States. Warm social relations are encouraged and informal lectures and discussions about problems of mental illness are part of the program.

By admitting relatives of the patients to club meetings, mental-hygiene workers have been able to equip the families with better understanding and with the means for giving more adequate care to the home-coming patient. Ross has reported about similar projects in Canada. An interesting experiment on this order has been made by the New York Veterans Administration with relatives of epileptics.

This type of group work is an important contribution to the goals of preventive psychiatry. It has succeeded in reaching an ever larger number of the population with enlightening information about the nature of psychic disturbances and their treatment. Furthermore, this work is waging a large-scale campaign against superstition and the magic horror surrounding the mentally ill. Attitudes of rejection and fright in the community often prevent the afflicted individual from getting early treatment, impede his return to family and social life, and are responsible for a high percentage of relapses.

Group Therapy in Mental and Penal Institutions.—The literature on group therapy with psychotic patients in large mental institutions offers many interesting and stimulating ideas for the field of mental hygiene. Pioneer work has been done by Lazell and Klapman. An essentially dynamic orientation had been modified into a type of school system with syllabus and homework for the patient. "Classes" are usually held in the midst of the ward and patients can join if and when they wish to.

Abrahams developed a far less structured system in his group work with psychotics. He spent many hours at a time on a disturbed ward of psychiatric criminals, soldiers returned from overseas to Washington, D.C., because of violent, assaultive behavior. Abrahams, by adjusting himself to their milieu and conversational level, learned to establish contact with violent, paranoid, hebephrenic, katatonic patients and with prisoners suffering from detention psychosis, thereby exercising definite therapeutic influence.

N. Breckir has made pertinent observations on groups of schizophrenics from the rich material available at Brooklyn

State Hospital, New York City. His reports show a new insight into the functioning of schizophrenics and their interrelations in groups. The results of his research are now used widely by the U. S. Veterans Administration.

My own experiences in intensive group work with psychotic war veterans confirm these observations. What I found to be of primary value in institutional group therapy is its impact on the attitude of the personnel toward the psychotic patient. This is true for psychiatrists, attendants, and nurses alike. The patient is no longer regarded as a creature hopelessly beyond our own world of experiences, one who cannot be reached, but who must be kept in check by more or less forceful means. He is seen, instead, as a human being, whose personality, while severely disordered, still has some available areas of function. There is no illness that is a "total illness."

This new orientation is of greatest importance in the training of an institutional staff. Through participation in the group work with patients, nurses and attendants learn to accept the patient as their human equal and to give him status in the group which represents human society. To put theory into practice is not an easy task for the staff. It takes intensive training to discard the long-standing attitude of contempt for the mentally ill as an inferior creature; to learn not to respond to bizarre ideas and behavior with ridicule, mocking indifference, or punitive measures, but to accept them seriously, with patience, kindness, and every attempt at understanding the patient's ways of thinking and acting.

To achieve this we have to understand the "undercover warfare" between patients and staff which exists in many mental institutions. They live in mutual fear of each other, and it is impossible to develop self-discipline among the patients as long as they feel threatened by a pseudo-authoritarian attitude of the attendants, maintained through threats and punitive measures. In the course of group work, a relationship of trust develops between patient and staff. As a result of a friendlier general atmosphere, patients make better contact among themselves. As soon as the patients are more relaxed, recourse to sedation or to disciplinary measures is rarely necessary.

Another important aim of group therapy in institutions

is to ease the fears and tensions of newly admitted patients by dispelling the impressions of mystery and hush surrounding institutional procedures. The functions of the staff are explained to the patient through "orientation group sessions." He is informed about the purpose and the legal aspect of his institutionalization; also about the therapeutic and diagnostic techniques that will be applied. Even confused and hallucinating patients are surprisingly receptive in discussion groups, and give and take lucid explanations about such complicated procedures as electro-shock therapy, encephalography, spinal taps, Rorschach tests, and so on. Psychiatric terms lose their awesomeness through simple, straightforward explanations which help greatly in reducing the apprehensions of the patient in the admitting ward. We can readily see why this kind of enlightenment about medical procedure and medical terminology is of equally great importance for the mental health of everyday life.

Among the effective methods for the promotion of group mental hygiene in institutions and hospitals, extensive occupational, educational, and entertainment programs play a large part. They were started in most United States institutions a good number of years ago under the influence of Adolf Meyer, one of the founders of the mental-hygiene movement in North America.

Not only the mental hospitals, but penal institutions also employ group methods with their inmates. A group of progressive prison workers, under the leadership of Lloyd W. McCorkle, have pioneered in this field for the past few years. Work of this type was started with criminal soldiers during the last World War in the rehabilitation center of Fort Knox. Inspired by group-therapeutic concepts, McCorkle and his collaborators have applied their progressive methods of permissive discussion groups and clubs with self-government in numerous prisons and reformatories in the United States. Their efforts have shown that group procedure originally intended to serve therapeutic goals can be used in the rehabilitation of delinquents and social misfits—*i.e.*, persons in conflict with society who are often not regarded as mentally ill.

Influence of Group-Therapeutic Methods on Morale and Social Attitude in Family, School, Army, and Community

Life.—Through experience with the psychoneurotic patient, psychoanalysis has derived deep insight into the functioning of the so-called normal personality. By the same means experience with the therapeutic group has thrown new light on group psychology as it manifests itself in everyday living, and from there a new perspective can be gained on community life as it functions in our complex society.

The therapeutic group brings to the surface negative as well as positive feelings, laying them bare to scientific investigation. The patient's behavior is not always pathological, and many behavioral manifestations are considered pathological not because they are qualitatively different from those observed in the daily life of the so-called normal individual, but because they are quantitatively distorted—*i.e.,* exaggerated or diminished.

We can thus see that the mental-hygiene movement, which is concerned with a future of sounder human communal life, will be able to profit greatly from experiences gained through group therapy. It is inevitable that any betterment of the psychological attitudes of the individual toward the community will have to start in childhood, being focused on the primary social setting of early childhood—*i.e.,* on the family. Let us, therefore, look at experiences gained in therapeutic work with children.

At the New York Jewish Board of Guardians, group therapy with disturbed children and adolescents is conducted under S. R. Slavson's direction. Slavson's activity groups represent a setting of great permissiveness, in which the leader (parent substitute) never rebukes, orders, or suppresses, but meets the hostilities and aggressions of the members with equanimity and friendly understanding. The success of this treatment method indicates that this synthetic family group contains the elements of ideal family and school life. Other observers, in particular Redl and Meng, have confirmed this viewpoint. This approach is far from having attained realization on a large scale. Much effort and time will go by before education will be founded on love, friendly understanding, and encouragement, before mutual helpfulness between adults and children will replace the authoritative system of discipline "from above."

Preventive as well as therapeutic group work based on this

permissive orientation aims to reduce anxiety and tension, to help the individual to accept and understand himself and others more fully, and to enable him to function in an expanded social environment. If through contact with a permissive parent figure and with group members (siblings) who accept him, the child's inferiority feelings subside, if he is able to mature, and to increase his frustration tolerance, we may then consider these experiences in group therapy as the model for mental-hygiene projects aimed at promoting improved group morale and group function within the community.

The neurotic individual and the mentally ill patient are often regarded as the victims of social evils—*i.e.*, of pathology in group life. If it is through a therapeutic—*i.e.*, an artificially composed, but more adequate—group that they improve, we begin to see how group or social pathology could be eliminated by similar treatment methods aimed at improved group living. Here lies an enormous task for a strong and progressive movement in preventive psychiatry, trying to create a sounder society.

Therapeutic group work with several members of one family and with a total family group has further improved our knowledge about intra-family relations and basic group mechanisms. Family group therapy in child guidance is of particular importance in the psychotherapy of younger children whose dependence on the home makes the treatment of disturbed family relations essential for the progress of the child under treatment.

Stimulated by the work of Dr. John Bowlby and his collaborators, as presented at Tavistock Clinic during the Third International Congress on Mental Health in London, we have tried the reduction of intra-family tensions through group sessions with the whole family. In our experience with family group therapy we found that the presence of the therapist and the social worker (both parent figures) at group sessions with the family enabled the members to handle better their anxiety, tensions, and hostility *not* only during the session, but also for the following days and weeks. Highly interesting observations on intra-family-relation phenomena could be made during these sessions.

At Brooklyn Guidance Center, Fabian, Crampton, and

Holden organized discussion groups for disturbed mothers under the leadership of one therapist while their children were treated in play groups by another therapist. Baruch and Miller conducted groups of patients suffering from allergies. The members brought their marital partners into the group and this resulted in a definite abreaction of marital tensions. Every one of these projects resulted in improved intra-family relations—*i.e.,* improved the mental hygiene in a social group.

Saul Scheidlinger, after an extended experience in group therapy, has studied the influence of the group upon the child in school. The material for his study on "Group Factors in Promoting Children's Emotional Health" was obtained at Walden, one of New York City's progressive schools. The individual child was studied as a member of a specfiic group with its own unique atmosphere and patterns of interpersonal relations—*i.e.,* the class.

While Scheidlinger has focused on the child in the effort to improve the emotional atmosphere of a school setting, L. Berman and his collaborators in Boston are working in psychoanalytically oriented groups with teachers and school principals. These groups have no direct therapeutic aims, and their members are not considered as patients. The release of tensions and the possibility of facing one's own assets and liabilities in a group of peers, with a psychiatrist as a leader and guide, has had very encouraging results for the participating teachers and for the schools in which they function as educators.

In two other important areas of social action, similar methods are used to integrate individuals into their natural social groups through reëducation in synthetic—*i.e.,* therapeutic—groups.

One such project comes from Miss Rose E. Drapin, of United Service for New Americans, a large social agency caring for immigrants. She proposed that recent immigrants who had been liberated from concentration camps be helped to adjust to a new environment and a new way of life through group therapy. On a very large scale, this type of rehabilitation has been carried on in the American and British armies. Group psychotherapy during the war years succeeded in reëstablishing battle and community morale in soldiers suffering from war neuroses. It afforded these soldiers the oppor-

tunity for free expression of otherwise prohibited criticism and hostility toward superiors and their orders. Morale and discipline were reëstablished among many members of groups that I observed.

Group therapy not only refitted the soldier for his duties, but helped later toward his return to an adequate place in civilian life. The participation of women (psychiatric nurses and Red Cross workers) helped to give individuals who had been separated from their families for months and years a feeling of belonging. The effects of this group work reached far beyond immediate therapeutic goals.

Group psychotherapy in the British army has yielded some interesting observations on the development of leadership in groups, and on the dynamic differences between groups with leaders and those that are leaderless. Some of the psychological mechanisms that operate in the relatively small psychotherapeutic group and that are open to scientific investigation appear to be qualitatively not different from those processes which the social psychologist meets with in his observations of mass reactions.

Mental-Hygiene Principles of the Psychodramatic Theater.—Since his early years in Vienna, J. L. Moreno has been interested in using the stage as a tool for the propagation of mental hygiene. Through him the stage of the Viennese Komoedienhaus became the playground for people from all walks of professional life who acted out as "kings" their ideas of ruling the world. Some time later Moreno opened his first Theater of Spontaneity (*Stegreif Theater*).

Psychodrama presents in all its aspects a thoroughly dynamic psychiatry. Because its therapeutic influence is intended to reach the spectators as well as the persons acting-out on the stage, it is in a very full sense also a psycho-hygienic group method. The psychodramatic stage attracts a great number of people who are not in open need of psychiatric treatment, but who attend psychodramatic sessions out of interest or curiosity, or who have been drawn to them because of a relative who is under treatment or in need of it.

The situations enacted on the psychodramatic stage concern many sociological and psychopathological topics, such as marital tensions, parent-child relationships, employer-employee conflicts, delinquency. Rôles are played by all those

willing to participate, there being no distinction between actor and onlooker. Trained "auxiliary egos" appear on the stage "acting as extensions of the [actor's] ego, strengthening [his] drive toward expression and realization."

Moreno has contributed not only the psychodramatic technique to the treatment of the mentally ill. His research and teachings have greatly enlarged present-day knowledge about the function of spontaneity and about interpersonal relations within social groups. The methods he developed in *Sociometry and Sociatry* originated in his therapeutic experiences with emotionally disturbed persons. His writings have had a considerable influence on the orientations of education, sociology, and social pathology.

In 1947 an attempt was made to popularize psychodrama and bring its educational message to a greater number of people. A psychodramatic stage, the joint enterprise of the theatrical director, Denes, and the psychologist, Russo, opened in New York City. Professional actors played on a program which consisted of six dramatized sketches, bearing such titles as *Anxiety Neurosis, The Masochist, Diagnosis, The Psychopath,* and others. Between skits the psychologist conducted discussion periods with the audience, interpreting and explaining what had been acted out on the stage. The program was advertised as "scientific, entertaining, and educational."

The purpose of this undertaking was to bring to the population a better understanding of mental disease and its treatments. This method of presenting and publicizing mental hygiene through dramatized sketches has been widely and successfully used by The National Association for Mental Health during the last several years. The American Theatre Wing Community Plays (*Temperate Zone* and others), which the National Association sponsors, have become an essential part of local mental-hygiene programs.

Summary

Group therapy on a scientific basis was originally developed out of the necessity of enlightening patients and their relatives about physical and mental illnesses. Didactic and ritualistic beginnings operated on the principle of authoritarian class methods and provided inspiration by means of confessions

and exhortations. A psychoanalytic orientation originating from individual psychotherapy developed later. Under the guidance of a loving and kind father-figure in a permissive environment, this form of therapy encourages the group member to release repressed emotional drives and enables him to adjust his relations to his environment on a sounder and healthier basis. Combinations of both didactic-inspirational and analytic methods are frequent.

While the didactic-inspirational method is useful in psychohygienic instruction and enlightment, analytically oriented group psychotherapy has stimulated the development of new forms of community life. Imposed discipline and authority are replaced by voluntary coöperation on the basis of mutual understanding and warmth in human relations. The influence of analytic group psychotherapy on communal living, on schools, and at home, in the army, and in institutions started only in the last few years. The great variety of methods applied in group psychotherapy provide a wealth of experiences with human interrelations. We begin to see results obtained outside of the relatively small number of individuals undergoing group treatment. A new awareness of mental-health problems acquired in these human laboratories is reaching ever-growing segments of the population. Group psychotherapy has significance not only as a treatment method; it is also a means for acquiring better knowledge about sound human functioning in community life. The therapeutic group is a proving ground for investigating on a small scale the problems of human interrelations. The same principles of group behavior are repeated in the vast, complex network that constitutes our society.

Group life that permits a maximum of spontaneity and provides equality of status, understanding, empathy, and support, without arbitrary interference through authoritative measures, makes up the essence of therapeutic group experiences, promoting new aspects of group living. An extreme expression of these ideas can be found in activity and other nondirective group techniques. The therapist who follows these methods refrains from advising and directing to the extent that no verbal interpretation is given. We can expect more valuable results from intensive scientific investigation of the

socio-psychological functions of and within the therapeutic group.

The new approaches that have opened up as a result of research in group therapy have had great influence on goals extending beyond mental hygiene. They influence education and sociology and finally will have their effect on the complex structure of national and international relations. Individuals successfully treated through group therapy learn to understand and to control prejudices and personal likes and dislikes and to use in human relations the unifying realities of the present instead of the dividing fantasies of the past. In a community consisting of a heterogeneous membership, they learn the principles of sound living-together.

We have tried to show the steps that led from a therapy for the individual to a therapy for groups, from group therapy to therapy for human society. This, in the final analysis, is the goal of all psycho-hygienic endeavor. We are still far from reaching this goal, but our experiences with group therapy so far indicate that at least we are heading in the right direction.

If scientific research, based on experience in the microcosmos of the therapeutic group can develop new principles applicable to community life in its broadest aspects, then it follows that the relations of larger groups and nations could be improved through the introduction of the basically new educational system in which authority from the top is replaced by the active coöperation of all members of society.

THE ADOLESCENCE OF CORRECTIVE THERAPY*

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AS you are well aware, the past year has brought to a focus some challenging situations for corrective therapy as a section of physical medicine and rehabilitation. Hundreds of therapists, working in a typical hospital situation in a coördinated medical program, are bound to have problems—problems associated with natural development and with a desire to improve their professional techniques and general medical status. I have been making an evaluation of these problems and, after giving the matter considerable attention, have come to the conclusion that the difficulties that call for solution in the field of corrective therapy are the natural problems of growth, the hesitancies and resistances, the physical and psychic pains of growing up.

And so in this paper, within the framework of the short history that has led to its present stage and development, I want to talk about the adolescence of corrective therapy.

I assume that this group has a general acquaintance with the history of our specialty—its growth in other countries, particularly in England and the European countries as well as in South America; and its inception in the Veterans Administration in 1946. To this must also be added the pioneering contributions of Howard Rusk and others too numerous to mention who gave much of the modern spirit to the present dynamic concepts of rehabilitation.

At the outset, it is only natural to ask ourselves some questions about the world into which this budding specialization is emerging: What kind of world is it? Is it friendly? Is it conducive to the development of these ideas, ideals, and physical structure? Is there a place to-day for corrective therapy?

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The answer to these questions will divulge the future as well as the present status of our discipline.

It has been aptly stated that atomic warfare can stop an individual or an army, but that so far no way has been devised to stop an idea if the idea is vital, realistic, and meets a basic need. The basic idea of corrective therapy stems from the fact that life is motion and that an individual in motion is better prepared to meet his psychological as well as his physical needs. Progressive medicine has developed a most realistic rationale of activity in relation to treatment, in giving exercise and activity the dignity and status of essential components of treatment. Corrective therapy is emerging in a hospital environment as the development of this basic concept of medicine. Exercise has become a part of planned activity, which in turn is related to the need of the patient, not only to regain the function of a paralyzed limb, for example, but also to leave the hospital, go home, and get a job. This employment objective opens an enlarged vista of very great promise and usefulness, an era that will interest and challenge the corrective therapist to study the personality of the patient, to find clues and lures that will enable him to help himself, that will develop the will to get well and the stabilizing hope of preparing himself for the satisfactions of independence and economic stability.

The corrective therapist is entering an era in which the concepts of rehabilitation are being structured into national policy. During the fiscal year 1950, 71,543 persons were rehabilitated and placed in employment under the federal-state program of vocational rehabilitation, the greatest number of persons rehabilitated under the program during any one year. While this is significant for the present, the future holds even greater promise. The federal-security administrator has stated: "Only a fraction of the total number of handicapped persons needing service from the national defense program are at present provided for."

In this connection, I recall an incident during my visit to this city a little over a year ago, when I was privileged to attend a meeting of the Los Angeles Welfare Council, at which the film, *Journey Back*, was presented to demonstrate the psychological problem of the hemiplegic and the methods of physical medicine utilized to effect restoration to physical

usefulness. An interesting discussion followed, in which the techniques of activity and the approach to the emotional problems of the patient were considered. The main point that came out, however, was the fact that there are probably thousands of hemiplegic patients in Los Angeles and its environs now in wheel chairs or in bed, who could become ambulant and regain a life of freedom, if only they knew of the possibilities of a medically planned and supervised program of exercise and activities, directed toward the restoration of the ability to walk, dress, and feed one's self.

This incident points up another aspect of the world the corrective therapist lives in to-day. The techniques of progressive medicine must be explained to the public. The corrective therapist is emerging into a challenging world in which he is given not only the responsibility of treating patients, but the added duty of explaining what he is doing. The physician has the responsibility of directing such public orientation. The over-all opportunities for education are becoming more apparent to-day than ever before.

In discussing this phase of treatment recently with the chief of physical medicine of a veterans hospital, I was interested in his evaluation of the chief of corrective therapy. "After I examine the patient and give the prescription," the doctor explained, "the therapist takes the patient aside and tells him about the exercise—not just a few generalities, but the purpose of the exercise, the correct ways to perform it, the time elements involved, the probable end result. And then the therapist tells the patient about other patients who overcame a similar disability, and in many resourceful and ingenious ways gets close to the patient, makes him feel that they are doing this together and will enjoy the rare rewards of companionship and mutual effort. The patient soon learns that the therapist is not a muscle man, that he is dealing in human values, and that friendliness and mutual respect are a most important part of the techniques employed."

Corrective therapy is entering a world of evolving industrial relations. The acceleration of production, attuned to both a civilian and a war economy, has produced the present tempo of industry, and while the newer concepts of management-employee relations acknowledge the importance of the emotional adjustment of the worker, the overpowering spirit

of America is for increased production. Dr. Thomas Rennie reminds us: "In our democratic and capital society, industry operates upon a particular principle—namely, that materials, plus technology, plus the worker, plus management, enable us to produce goods at the lowest cost and hence a higher level of living for all. The second law is that the value of goods minus the cost of production equals profits. With our particular genius, we have solved every aspect except one and that is the worker-management problem. Industrial engineering has failed to meet the greater problems of human engineering. We can solve the technical problems only to fail in the problems of human relations." Now what does the corrective therapist have to do with this? you ask. I would hazard an answer along these lines:

The problem to-day is not to train the worker exclusively in a special skill or technique. Dr. William Menninger has said: "Although most professional people make their living by the use of intelligence, which may or may not be supplemented by the toil of their hands and the sweat of their brow, every one makes his life through his emotions—through loves and hates, faith and hope, jubilations and disappointments. They are the vital part of life."

And so the corrective therapist enters a world that is becoming sensitive to the many significant relationships between emotions and activities. He is entering an industrial world in which the acceleration of production and the profit motive are coming to grips with mental-health aims and objectives. The discipline of corrective therapy must grow along with these contemporary developments, so as to become a part of the progress of industry as well as of the progress of medicine.

Corrective therapy is entering a world of geriatrics, a world in which more people are living longer. The tempo of the present was expressed by a former president of the American Medical Association when he said, "Now that new medical techniques and understanding have added years to life, it is our responsibility to add life to years." We should be cognizant of the dual nature of this achievement in longevity and the responsibility of our profession to devise methods that will add to the years of the older person while providing him with emotional experience—that will give him a vital perspective for continuous living in terms of freedom, dignity, and

respect. As Dr. H. Levine has pointed out, the man of sixty-five to-day is a very different person from the man of sixty-five of the 1800's or early 1900's. He is a much stronger person, much healthier and more dynamic.

> "When the average life expectancy was thirty-five in 1800, a person of forty was comparatively old; when he achieved an average life expectancy of forty-five in 1900, a person of fifty was a comparatively old person. Now that we live to be almost seventy, a person of forty or fifty is comparatively young. In a shorter lifetime, he worked as many hours as he does now in a longer lifetime. He works under conditions much more favorable to his health in terms of sanitation, heat, light, and transportation. In the past, if he managed to reach sixty-five, he was a tired old person. To-day, a sixty-five-year-old person has an interest in and a zest for living, a need to be active and to participate, and why not?—for at fifty-five he has a life expectancy of close to twenty years; at sixty-five, of thirteen years. Even at seventy he still expects to live for ten more years."

These millions of aged and aging people will need the services of scientifically graduated and planned exercise and activity for the maintenance of their health. One can expect increased numbers of chronic invalids from their ranks. In addition to the element of longevity, the acceptance of the old by society, the perfection of new treatments and techniques, provide dynamic factors in a revitalized science of gerontology and give opportunities for the alert corrective therapist to be of service in a rapidly expanding field. Statistical studies indicate that there will be nine million veterans over sixty in 1990, another indication of the practical importance of this problem to the Veterans Administration as well as the public at large.

The corrective therapist is entering a world of intensive and stupendous scientific development. Any one who attempts to evaluate this progress to-day is faced with an endless task. Every avenue of life is being examined by the cold lens of scientific observation. Entirely new fields are being discovered, and within these fields innumerable sub-specialties are being developed. Drastic and heroic therapies are applied to the problems of psychiatric treatment. The field of psychosomatic is becoming more closely allied to science; techniques of neurological rehabilitation are changing the prognoses of many illnesses; and new objective aids to diagnosis are emerging in the never-ending quest for improved health

methods. Happily, corrective therapy is becoming a part of this wave of scientific progress.

A new concept of exercise as a functional activity has added significant meaning and a very practical utility to corrective exercise. This new concept simply means that physical exercise must serve a useful, practical purpose if it is to become an adjunct to medicine; that it must get away from merely amusing the patient and catering to his whims, from making people strong and alert, important as these aims are in individual cases. Corrective exercise must assist the patient to develop his own potentials for a mutual attack upon the illness both by the patient and by the therapist. The techniques of the therapist begin to revolve about the practical areas of retraining—feeding and dressing one's self, for example. The therapist thus gets away from the rôle of the muscle man or coach or even the teacher of health education. His specialization involves an understanding of the pathology of disease in relation to exercise techniques applied to specific physical and mental conditions.

A more exact dosage of exercise and activity has been the aim of various investigators, and it is leading to progress in the direction of more specific prescriptions. This aim has accompanied the long trail of medicine over the past hundred years, culminating in real progress during the present century. Dr. Sidney Licht, in his *Early History of Occupational Therapy,* describes the institution for treatment known as Consolation House, organized in the early 1900's in which activity was to become the main treatment. George Barton, an architect, was in charge, and his idea was that the first thing to be done "is to provide an occupation which will produce a similar therapeutic effort to that of every drug in materia medica, an exercise for each separate organ, joint, and muscle of the human body."

Suffice it to say that Barton's architectural ideas were not applicable to the organization of medical techniques, but did reflect a trend toward a more specific application of exercise for medical treatment. To-day the corrective therapist is entering a new cycle of constantly changing concepts of treatment in which more precisely formulated applications of exercise and activity are required.

This growing young discipline, corrective therapy, is enter-

ing a significant field of clinical practice, and it is here that its eventual worth will be determined. It is here that the youthful buoyance of adolescence and the mature counsel of the physician may blend for the development of valid techniques of treatment. The importance of clinical practice as a basis for the most effective practice of therapy is being stressed in medical circles to-day. Just what happens to the body and to the personality of the patient when he becomes an active part of his treatment rather than a negative recipient can be determined only upon the basis of results achieved in daily working with him in an active treatment situation.

The Veterans Administration fully realizes this fact and has continued to stress the value of training its therapists at the clinical level. Many of you are aware of the new probational requirements issued by the Veterans Administration which call for clinical experience in addition to graduation from an accredited school, as a prerequisite to employment as a corrective therapist.

In even a cursory examination of the voluminous record of clinical data now being amassed by the Veterans Administration, covering 151 hospitals and well over one hundred thousand patients, one cannot fail to find significant evidence of medical progress in the deft employment of medical activity techniques. Many instances could be cited as indicative of the opportunities and challenges and the results achieved. I will give one representative case.

This report details the activation of a corrective-therapy unit in one of the large neuropsychiatric hospitals of the Veterans Administration. The forty-nine patients assigned to corrective therapy were chronic and acutely disturbed psychotics, mainly schizophrenics. The greater number had already been treated by the various shock-therapy methods (electric and insulin) and several had had bilateral prefrontal lobotomy operations. Because of their uncontrolled, disturbed behavior patterns, they were unable to participate in the other hospital activities. The low percentage assigned to activities took an apathetic attitude toward them and performed in a perfunctory manner. The one common trait was combativeness, followed by destructive and unpredictable behavior. It was necessary to use sedative hydrotherapy treatments with

them, consisting mainly of wet-sheet packs and continuous tubs.

After repeated discussions between the psychiatrist and the therapist, treatment aims were formulated to meet the distinctive needs of each individual patient. These aims fell generally into two classifications: (1) the provision of socially acceptable methods for the expression of aggression; and (2) increase in social participation. After a review of each individual case, an attempt was made to determine the operating level of the patient and to prescribe for this level of activity. The activity was then constructed to meet his needs and capabilities. Patients were treated individually and regularly. An attitude of unsolicited friendship was maintained and the patients were closely supervised.

The first activity, which offered the patient an opportunity to express his aggressiveness and hostility in a socially acceptable manner, provided the stepping stone by which the patient could be led on to some more demanding activity. As the patient began to quiet down, he was moved to another type of activity that placed moderate demands on his personality. Promotion from individual to group situations allowed a gradual progression into more social appreciations and practices, as the therapist added new activities and perfected modifications of various sport and exercise regimens. Patients began to play with one another and to merge their personalities toward more constructive aims.

This activity resocialization process as part of a total psychotherapy, along with the participation of other sections when indicated, led to a reduction of 67 per cent in the number of tubs and packs required.

This growing entity, corrective therapy, as it emerges into manhood, finds a new world of social understanding and appreciation of illness, a world in which society is beginning to assume a far greater responsibility for the sick person. Bleuler's definition of mental illness as the exaggerated inability of the individual to get along with people served to call attention to the fact that illness includes far more than the sick person; it includes his fellow man and the attitude of society toward the illness, the willingness to accept certain manifestations of illness as valid, in some cases to be paid for by the government through pensions and other methods of

compensation. But even more important, it includes the acceptance of a status of co-responsibility of the public and the patient in working together for the general improvement of individual and collective health.

John Galsworthy put these concepts in sharp outline in 1918, when Great Britain was in the throes of a life-and-death struggle, with victory uncertain and the toll of the disabled appalling:

> "Body and spirit are inextricably conjoined; to heal one without the other is impossible. If a man's mind, courage, and interest be enlisted in the cause of his salvation, healing goes apace, the sufferer is remade. . . .
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> "A niche of usefulness and self-respect exists for every man, however handicapped; but the niche must be found for him. To carry the process to a point short of this is to leave the cathedral without the spire. . . .
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> "Let us treat him as if he were ourselves; let us treat him as one who demands a full place in the ranks of working life, and try to find it for him. . . . To restore him, and with him the future of our countries, that is the sacred work."

Colonel John N. Smith, Director of the Institute for the Crippled and Disabled, envisions the patient as "a member of a family and an economically productive and socially useful member of society, as having the right and duty to share equally with his non-disabled contemporaries both as a contributor to and a beneficiary of the cultural, political, and economic life of his community—the master of his own destiny and the architect of his plan of life."

Upon my visit to Los Angeles last year, I was fortunate in seeing an illustration of the effectiveness of a genuine and understanding participation of the public in treatment. A group of volunteers, under the direction of that very fine personality, Louis Moran, had arranged regular dance sessions with the very sick catatonic patients at Brentwood Hospital. There were thirty-two patients in the group and almost as many volunteers, who had undergone a most complete orientation and training. With the assistance of the corrective therapist, who introduced them to the individual patients and gave them information as to the background of the patient's participation, a most carefully planned dance social hour was arranged.

Beginning with stimulating music as a sort of introductory attitudinal medium, the patients quite naturally grouped

themselves in a circle, clasping hands with the volunteers. Starting at first with slow movements, the tempo and complexity of the dances, reinforced by simple games and play activities, were increased until the entire group was engaged in a group activity that was both pleasant and purposive and that served to create a feeling of unity. Negativistic patients, whose withdrawal from social life so profoundly affects their psychomotor reactions, began to loosen up, to smile, and in some cases to talk voluntarily with their hostesses. Every patient took part, and the extent and character of their reactions were beyond anything I have ever seen before in similar groups of patients. The genuine interest of the volunteers, combined with a rare appreciation of the personalities of this group of profoundly ill people and a deft utilization and modification of various dance and play routines, produced a most significant result. Such incidents serve to illustrate illness as a web made up of many threads which doctors and therapists are attempting to interweave into a social pattern.

Now to get back to the corrective therapist in a period of the life of his profession which we shall have continued to refer to as adolescence, the stage before full maturity. In this connection I am reminded of the advice of Irwin Edman, professor of philosophy at Columbia University. He advises people to get lost, and tells this story to explain why. Frank Giles, the ranch foreman of the Three Rivers Ranch, at which Edman spends his summers, was particularly worried lest the doctor should lose himself in the dusk in his long daily walks.

"A lot of these trails are just cattle trails," he said. "They don't lead anywhere. You can easily get lost."

"Oh, don't worry about me," Dr. Edman countered. "I've never been lost in my life."

Frank looked at him solemnly. "Anybody out here," he said, "who says he ain't never been lost, ain't been very far." Dr. Edman accepted this as a watch word expressive of the hope and risk that are the mark of a pioneer civilization and of an honest philosophy. It has a distinct application to our association and to our discipline.

Yes, corrective therapy is not mature as a profession. When looking around for a subject that I felt would have some practical import for this meeting, I was fortunate enough to discuss the matter with Dr. Alan Gregg and Dr. Knudson,

both of whom encouraged me in the selection of this topic and made suggestions as to its development. Knowing his deep and discerning interest in this group, I asked Dr. Gregg if he would find time in his very busy life to append a message to our membership along these lines and am most happy to bring his statement to you:

> "As the conditions of our lives and living constantly change, new callings and professions come into being. The profession of electrical engineering hardly existed a hundred years ago. Indeed, hardly a decade passes in some of our universities that does not witness the establishment of a new school or institute for the training of recruits to some new or young profession or calling—public health, aeronautic engineering, electronics, biophysics, to cite but a few.
>
> "In some ways a new and growing profession can be said at a certain point to be in the adolescent stage of growth. We all know adolescents. They are often a headache and just as often a heartening surprise. They show awkwardness and acute self-consciousness. They are unpredictable. What they do not exaggerate, they ignore, neglect, or omit entirely from their reckoning. They scorn patience, compromise, tolerance of others, and the long view. They rear and plunge and sometimes shy at trifles. They make passionate assertions and violent objections. But despite all these oddities of conduct, they feel within themselves unfolding abilities and nascent power, and their minds and hearts are in the future. Their hope, their confidence in the subject is unbounded and their confidence in themselves steadily increases. When a profession is adolescent, it is interesting, inviting, and alive, full of potentialities, of errors, hits, and runs."

As individuals and as an association interested in a practical approach to the patient, we have felt the urges and pressure of this formative period of our growth. Errors have been and will continue to be made. But we confidently expect that hits and runs will more than counterbalance these errors as we continue, with the aid and under the direction of the medical profession, to develop the potentialities of corrective therapy in the Veterans Administration.

American democracy will not allow these individuals to suffer neglect. With the new advances in the control of communicable disease and modern medical paraphernalia, one doctor can do what ten doctors did fifty years ago. More stringent professional standards, more efficient education, improved hospitals and home care, make his ministrations more effective. However, while the control of communicable disease has removed many patients from the area of treatment, the chronically ill more than take their place. The nine

and a half million aged veterans predicted for 1980 will represent but one segment of our population. The future will require many more therapists than can be visualized at the present time and far more than we can possibly provide for in our present courses of instruction. Corrective therapy, utilizing the dynamic modalities of exercise, activity, and interpersonal relationships, has an opportunity for service that will undoubtedly increase with the passing years.

THE MENTAL-HYGIENE CLINIC IN AN ORGANIZED HEALTH DEPARTMENT

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FOR a year and a half, the Baltimore County Mental Health Clinic has been operating a one-day-a-week all-purpose clinic. This program was initiated from funds allocated under the National Mental Health Act to the Maryland State Department of Health. The fact that Maryland has designated the state health department as the agent for the administration of these funds has helped to stress the preventive intent of the program. Since the clinic is a part of an organized health department, it is strengthened by the philosophy and the goals of the public-health program which not only gives service, but tries to educate the people with whom it comes into contact.

The psychiatrically trained staff consists of a full-time psychiatric social worker, two psychiatrists, and one psychologist, who give service only on the clinic day. Since the social worker is the only full-time member of the staff, she assumes administrative responsibility for the clinic program. This involves arranging the clinic schedule, taking care of correspondence and reports, and following through on recommendations, in addition to being the social-work member of the clinic team. She also serves as consultant on mental-health problems to the public-health nurses. She has been given the title of "mental hygienist" and is administratively responsible to one of the assistant health officers who heads the program medically and who is responsible to the health officer.

The present success of this mental-health program at the Baltimore County Health Department has been due to its integration as a part of the over-all health-department program. The emphasis has been on making this one of the many health-department services, in an effort to break down the stigma that many people may feel is attached to a psychiatric

out-patient clinic. In this way, people are more likely to seek help before their problems become acute, since they are not blocked about using a health-department facility.

In this program the public-health nurse has been fully utilized as a part of the service. In referring cases, she has been incorporated as a member of the clinic team. In her everyday work she is constantly using mental-health principles which become more a part of her equipment as she works with the clinic team.

This utilization of nurses as a part of the intake service of a psychiatric clinic marks the departure from the orthodox procedure, in which intake is handled by the psychiatric social worker. Certainly the social worker, by virtue of specialized training and skill, can, if she has the time, utilize intake as a vital part of the initial treatment and case-work process. Yet, in pioneer settings such as the one described, where time and specialized training are at a premium, we have found that this departure from the usual procedure has not jeopardized our results. We have had very few broken appointments and most of the cases referred have been well prepared for our service. Because of the soundness of this initial preparation by the public-health nurse, even if we acquired more trained social workers, we would not eliminate what the public-health nurse is doing, but would only reinforce the process by having each patient see the social worker before the clinic appointment. Now, this is possible only in a minority of our cases.

The public-health nurse, because of her training and relationship in the community with all age groups, has proven herself a valuable asset to the clinic team. As already indicated, she can prepare the patient for the service. She can also provide the clinic with background information in the form of a social history. Since many of the families referred are already known to her, she has a wealth of accumulated facts, both medical and social, which are valuable to her other team mates. She is in a position constantly to interpret the service, and as her work becomes more integrated with the skills and techniques of the psychiatrically trained members of the clinic team, she is able to impart her new knowledge and understanding to the people she comes in contact with on her own working level.

In order that public-health nurses might be utilized in this way, a sound orientation program was worked out. A few staff meetings were held, at which leading psychiatrists in the area went over some of the basic mental-health principles that would be applicable in public-health nursing. We then focused on case finding and setting up structure that would serve as a helpful guide. For example, the stipulation that a person take the initiative in calling to be put on the waiting list before his case is accepted or worked up, has been an important step in this process. Even more important is the fact that the public-health nurse goes into the general health of every person considered for the clinic, so as to rule out anything organic before the problem is approached as an emotional one.

We have developed a brief form which covers these basic points and which is filled out by the nurse before a case is considered for the clinic. In reference to the social history and background information, we have provided a guide of information which we feel is important for an understanding of the person as a whole. But unless this information is already available, or the person feels free enough to supply it, we have not insisted on coverage of every point. It has been our experience that the public-health nurse has had most of this information from her contacts with the person even before she considered the mental-health problem, and we have felt it to be a time-saver both to the patient and to the other members of the team to get this already accumulated information. The social worker can then use her first interview to get any other points necessary for the clarity of the service and to begin to discuss how the clinic will help the applicant decide whether this service is something that he wants to utilize.

Regular monthly regional mental-health conferences are held by the social worker with small groups of nurses and their supervisors to discuss these potential cases and select those most able to utilize the clinic service. At this conference the cases already referred are reported on. Through these reports and group discussions, each profits by the experiences of the others and the group is being educated as to whom to refer. This process also helps the nurses to help potential

applicants recognize their need for assistance and use the service to the best advantage.

The visiting teachers are invited to attend the part of the conference devoted to school children, thereby integrating the services of the board of education and the health department. Consultative service on those cases that are not accepted for clinic service and on general mental-health problems is provided. Staff education is carried on through these discussions, and the public-health nurse gets some direction as to how to administer her services from the mental-health point of view. Through this in-service training, she is better equipped to handle the new rôle that is delegated to her. At least twice a month formal case presentations are held during the last hour of the clinic day and further staff education as to what the clinic is doing is provided. At this conference all professional staff who are interested in and working on the case are invited to attend. Each person attending summarizes his part in the case and a collaborative plan is worked out.

In order to illustrate how the service has worked, I will summarize one case—that of C. T., a twelve-year-old boy who was seen at our clinic for about a year. This was one of our very first cases. It was referred by the public-health nurse at a regional conference after our in-service orientation, at which time, as stated previously, emphasis was put on the types of case to be referred and particular stress was given to the tie-up of other physical complaints with emotional problems.

This child was first brought to the attention of the nurse when he visited the health room at school complaining about his eyes. The public-health nurse advised him to have his parents consult an oculist. He returned to the health room several weeks later with the same complaint. This time the public-health nurse suggested to him that perhaps she should visit his home and talk with his mother.

C. seemed reluctant about this and hastily said that his mother would not be at home. The public-health nurse visited the home anyway and found the mother at home and most receptive to her interest. She learned that the child had been under the care of a well-known ophthalmologist and that at

the close of the school year arrangements were going to be made for a corrective eye operation. Further discussion revealed that Mrs. T. was very much troubled by C.'s behavior. She explained that although he was large physically, he was not athletic and was very unpopular with his playmates. The ophthalmologist felt that the family should consult a psychiatrist because C. had been too fearful to undergo a corrective eye operation the year before.

After the public-health nurse got other pertinent family information, she discussed with Mrs. T. her feelings about following through on the ophthalmologist's suggestion. She then told her about the new health-department mental-health clinic. Mrs. T. expressed an interest in following through at the mental-health clinic. She said that both she and her husband were well aware of her son's problem.

After the case was accepted at the regional conference, the public-health nurse had Mrs. T. call the clinic for an appointment. She prepared her as to how the clinic functioned. Mrs. T. knew that she would be working with the social worker and that C. would be seen by the psychiatrist. It was further understood that we would not know until he was seen diagnostically whether treatment would be recommended, and that this would be determined after the first few appointments. While C. would be working with his problem with the psychiatrist, Mrs. T. and her husband would be working on what they could do to help him and would also be sharing his progress while under treatment.

Before Mrs. T.'s first appointment with the social worker, the public-health nurse sent in the social history that she had on the family. A brief résumé of her report indicated that C. was very bright at school, was an only child, and had other symptoms besides those already mentioned, such as fainting spells, stomach upsets, and rebelliousness toward his teachers at school. Mrs. T. realized that she might have been overprotective to him, but felt that she would rather face her mistakes now than let things go on. The parents were described as being in their early thirties and living in a comfortable neighborhood in an attractively furnished home. Mr. T. had had two years of college as an industrial engineer, and Mrs. T. was a high-school graduate. The parents

impressed the public-health nurse as being happy and as interested in the welfare of their son.

The first interview with Mrs. T. indicated that she had been well prepared for the clinic. The psychiatric social worker focused on the immediate problem that C. was presenting and indicated where she wanted to begin on her part of the problem. We reviewed the matter of preparing C. for his first appointment—putting it on the basis that since he had not been getting along too well and was not too happy, she was bringing him to the mental-health clinic so that he could try to understand what was causing this and so that they could both see what they might do to make things happier at home. Mrs. T. affirmed that her husband was interested and would be willing to come for appointments. This had to be delayed at first because of business reasons.

After this first appointment, C. was seen by one of our psychiatrists, who felt that he would be a good possibility for treatment, and both C. and Mrs. T. were scheduled to come to the clinic for regular weekly appointments.

In therapy, C. was very eager to make a good impression on the psychiatrist, and it was some time before he could feel secure enough to express his feelings and begin to face his problems. Case-work with Mr. and Mrs. T. was much more rapid, since they were very eager to bring their problems to their interviews and immediately began to look at some of the things they had been doing with more thought. They began to have more understanding of C. as they recalled the various things in the past that had had a part in creating his present fears.

Mrs. T.'s main problem centered around her inability to take any responsibility for facing C. with his behavior and thereby helping him grow up. She left everything up to Mr. T. to handle when he came home from work. Mr. T., a very rigid and perfectionistic person, had been very severe with C. and his punishment only made C. act more babyish and immature. C. would then make Mrs. T. feel very sorry for him and try to get her to side with him against his father, and this led to more friction. As Mrs. T. brought specific illustrations of these problems to her interviews, she began to find out how she could be firm with C. and how in this firmness she would be more helpful than by maintaining the over-

sympathetic, protective attitude she had previously shown. She was able to begin to assert herself and immediately began to see results.

C. was not seen initially by the clinic psychologist, since there was no question about his intelligence and it was felt wiser to have him start therapy and get him related to one person. When he was tested two months later, we learned that he had very superior intelligence. This information was very helpful in working with his parents, since their opinion of him was influenced by his shortcomings rather than by his assets. Particularly in my few interviews with Mr. T. was this evident. Mr. T. had felt that many of C.'s questions and comments were not to be taken seriously, and were only indications of "freshness" rather than of a superior and curious mind. As Mr. T. gained more understanding of C., he began to be more tolerant and more accepting of him and could consider his son on a more equal basis.

A case presentation such as I have already mentioned was held after we had been working on this case about three months. At this conference the school was represented and the public-health nurse was brought up to date as to our progress in a more intimate way than just by the brief report given by one member of the clinic team, myself, at the monthly regional mental-health conference.

Since the Baltimore County Health Department has started a very sound school health program which is already functioning in the elementary schools, this put the public-health nurse in a strategic position for obtaining information from the school as to C.'s adjustment, and to extend the arm of the clinic into the school environment when the need presented itself as therapy progressed. It also might be well to repeat here that it was in the school that C. first came to the attention of the public-health nurse through his visits to the school health room to see her during her hours on duty there.

It was interesting to learn that C. was not using his superior intelligence at school and was very insecure as to his abilities. This had been brought to our attention when Mrs. T. reported how upset C. had been after his tests with the psychologist, since he felt he had not done well. This was related to his emotional problems. As a result C. had no incentive to put forth too much effort because, regardless of what he did, he

did not feel it was good enough. This knowledge was beneficial to the school in helping C. recognize his own ability.

As therapy progressed, C. was able to share with the psychiatrist his feelings of inferiority, his fears, and his attitudes toward his parents—particularly his hostility toward and fear of his father. With the therapeutic support he received and the change in attitude on the part of his parents, he was able to work through some of his fears. He was able to talk about his eye operation.

At about this crucial point in therapy, he began to study first-aid in school and this aroused some of his earlier anxieties. He fainted and had to be excused from the classroom. In this situation, the public-health nurse was able to extend the arm of the clinic into the school situation, since by having her to talk through his school problem with him, he was able not to give in to his fears and go home, and later he could return to the classroom.

For the next few months the public-health nurse, through her position in the school and her knowledge of C.'s problem, was able to give him the additional support and understanding he needed when situations arose in school that he was still unable to face. As therapy progressed, his visits to the health room became less frequent and his adjustment at home improved. Finally, he was able to take the initiative to set a time for the eye operation and openly face with the psychiatrist his fears and anxieties about it. Liaison work was done between the psychiatrist and the ophthalmologist, so that the latter could be made aware of C.'s progress to date and the problems with which he still needed help.

C. was able to undergo the operation and returned to the clinic with a great deal of confidence and minus his glasses, which he had always felt were keeping him from engaging in sports. The public-health nurse had visited him during his convalescence and reported that he was outside with a ball and bat trying to get into practice. Within the next month the psychiatrist felt that C.'s basic problems had been solved, and although, from an idealistic standpoint, more therapy might have helped his personality further, our function is limited to short-time therapy and not child analysis. Mr. and Mrs. T., too, seemed to heve received enough from our service to enable them to handle their problems alone.

Since C. was now in junior high school and the health-department service has not as yet been extended to secondary schools, we felt that another case presentation would be of value before terminating the treatment, since this would enable C.'s new teachers to have the benefit of knowing what had been done and they would be in a better position to handle any other problems that might arise.

This proved to be a very fruitful enterprise, particularly to C.'s physical-education teacher, since C. had not been able to compete with other boys of his age and had been evading physical education. When the physical-education teacher became aware of C.'s background, he was able to understand his behavior and arrange a special project to help him become a part of the group and begin to feel some success in participation in sports. Our last report from the school indicated a good adjustment in physical education as well as in the other subjects.

This case illustrates the close teamwork that made the success of this case possible. In this type of health-department team, the rôle of the public-health nurse is being carved out and her contribution is of immeasurable value.

Helping to integrate a mental-health clinic into the workings of an organized health department has presented the older members of the clinic team with a new challenge. Those of us who have worked in psychiatric settings where this direct liaison to the community is not possible—because the service operates as a separate entity and not as a part of a multiple health-department service—cannot but be impressed and gratified by the over-all preventive aspect of our work. Through this affiliation with public health, and particularly when there is a health officer who is aware of the need and the assets of such a service, the clinic team is in a position to make a real contribution. As our services are put into practice and include the public-health nurse as a team member and a liaison with the community and the school, we are assured of the use of good mental-health principles in public health. And in this way our specialty becomes an integral and vital part of the general health-department service, meeting the needs of the public in a way that they can understand and utilize.

DEVELOPING A MENTAL-HYGIENE CURRICULUM IN A PUBLIC-SCHOOL SYSTEM

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THE teaching of mental-hygiene concepts directly to teachers and students is an essential phase of a total mental-health program in a school system. The development of mental-health courses makes it possible for a relatively limited psychiatric staff to influence the personality growth and development of large numbers of school children. Such a curriculum is thus an important aspect of the effort to evolve techniques for the quick detection of individuals in a school system who may be in need of help.

There is a new movement among educators to-day to stress the importance of understanding personal relationships. Occasional educators have recognized that when a child feels at ease and secure in these relationships, his learning capacity is markedly improved in the entire educational area. Hence they have gone ahead to find ways and means of teaching directly the meaning of these relationships. They have found various points of the curriculum at which mental-hygiene material can be incorporated. Actually, in many schools some mental hygiene has been taught for many years. But for the most part teachers have not been aware of the significance of the material; they have had no way to gauge the personal reactions of their children and the meaning of those reactions or to understand some of their own responses. They have not been able to measure the effects of such teaching. They have not always been able to recognize the individual whose behavior indicates a need for personal help and to direct him to the proper sources.

Psychiatric personnel in the schools can integrate the mental-health material available, help educators to understand the significance of the various relationships and group interplay, and offer supervision in channeling individuals to the proper

sources for personal help. In short, psychiatric personnel can help to develop a mental-hygiene curriculum.

Some of the problems encountered in setting up a mental-hygiene curriculum are (1) the development of an understanding of mental-health courses in school administrators, supervisors, and principals; (2) the selection of teachers emotionally suitable for the leadership of such courses; (3) the training of such teachers in an awareness of personal relationships and the meaning of group interplay and of their own reactions to the material brought out by the students; (4) the assembling of suitable teaching materials; and (5) the channeling of individuals in need of help to the proper sources.

In developing a mental-hygiene curriculum in the Cincinnati Public Schools, we have had as our basic philosophy the dynamic approach to an understanding of human behavior and the significance of personal relationships.

We have stated that the first problem in setting up a mental-hygiene curriculum lies in the attitudes and lack of understanding of school administrators, supervisors, and principals. There are several aspects to this problem. First, the psychiatric personnel must recognize that resistance to the initiation of such a program is usually based upon personal insecurities and fears. A mental-hygiene program can represent a rather considerable personal threat. Second, school personnel, possibly much more than other public-service personnel, are keenly sensitive to public reaction and the willingness and readiness of the general public to accept certain activities as part of a public-school program. Despite the presumed protection of civil service, they know only too well how quickly public furor demands a "sacrificial goat."

Two approaches are open to the psychiatric staff. Personal relationships with key school personnel can do much to give reassurance, to open up opportunities for understanding through the gaining of personal insight. Again, the psychiatric personnel must be opportunistic, must be on its toes for any opening, and must have an awareness of the point of development of each individual, so that it may be the jumping-off point.

To illustrate, World War II and a directive from the war department gave us in Cincinnati our first opportunity to

initiate a mental-hygiene teaching program. To-day our twelfth-graders have a required-credit course in "More Effective Living" as reported elsewhere.[1] In 1942, as part of the Victory Corps effort to prepare high-school seniors for military service and for life in a war-torn world, this course consisted of a series of ten lectures on mental hygiene, physical health, and social hygiene.

The physical aspect, which was supposed to include health materials not taught in other health courses and particularly applicable to military service, has been dropped. The mental- and social-hygiene sections have been retained and merged into a one-hour course given weekly throughout one semester.

Although initially patriotism was an impelling motive in influencing many hesitant principals to accept the course, later the students insisted upon its continuation and expansion. It is of interest that student demand sometimes existed in the face of strong opposition from principals and teachers.

Two examples can be given of the desirability of using the principal's interest and awareness of a need as a point of departure. One of our high-school principals was deeply concerned about the fraternity problem and the gap between the relatively sheltered life of a junior-high-school student and the complexities of a senior high school. When the football coach, who had taught the twelfth-grade course in human relations, after consultation with us suggested an experimental orientation course for ninth-graders, the principal accepted the idea with alacrity. When, after a classroom discussion of the fraternity situation, the numbers of those joining fraternities dropped off remarkably, the principal was sold on the idea.

To-day this high school has a ninth-grade orientation course for boys and one for girls. A full day at the beginning of the school year and much of the first week are devoted to making ninth-graders feel at home in the school and aware of its facilities and potentialities. Opportunities for questions and give-and-take discussions are given. From this send-off, ninth-graders continue their discussion of personal relationships in smaller classroom units.

As a further development of this project, meetings with the parents of freshmen students were arranged. Parents were

[1] See "High School Mental Hygiene Survey," by Jack Hertzman. *American Journal of Orthopsychiatry*, Vol. 18, pp. 238–56, April, 1948.

given the opportunity to ask questions, to participate in discussion, and in general to become familiar with the school's activities and courses. These parents' meetings have been extremely important in giving parents a sense of partnership in the work of the school and in making them aware of available resources when problems arise. At the invitation of the school principal, the psychiatric personnel attended these meetings and joined in the discussion.

Another principal of a junior high school in a tenement area was concerned about the conduct of a group of over-age, physically advanced, but intellectually limited group of boys and girls. They were attending school only because they were required by law to do so. They were not only not gaining a great deal from attendance, but they had a disturbing and disorganizing influence upon the other students. The principal was almost desperate and grasped at our suggestion of a course in human relations. The physical-education teacher undertook to organize the discussions as a part of his health-instruction program. Eventually he conducted six groups in all—two mixed groups of boys and girls at the ninth-grade level, two boys' groups in the eighth grade, and two boys' groups in the seventh grade. This teacher reported, "The student participation in response to class activities in general was excellent. . . . I believe they have a better understanding of individual and social problems and I think they show evidence of this in their behavior and attitude." It is of interest that when these students were asked to indicate in a questionnaire which discussions they preferred, they chose those involving their relations with others and very far down on their list put school interests, such as, "how to study," "improving your learning, interest, and attention"—this, mind you, from groups who live and act like "young toughs."

The second problem in developing a mental-hygiene curriculum is the selection of teachers emotionally suitable for the leadership of such courses. Traditionally, in Cincinnati as well as in many other communities, the physical-education teachers have taught health subjects. And so, when we started our twelfth-grade course, the physical-education teachers inherited the job. Some of them had a natural readiness for this type of teaching. Others were hesitant, indicated frankly that they knew little about mental health, and sought

help from the psychiatric personnel. Still others blocked completely and after some attempts were frank to admit that they'd rather not teach such courses. Still others went on to attempt the course, completely unaware of their own limitations or the pitfalls of such teaching.

From our experience it is difficult to set up at this time many criteria for the choice of individuals to teach human-relations courses. Certainly an interest in the personal problems of young people is important as well as warm personal relationships. There must be a sense of humor, a willingness to accept criticism from the group, tolerance of individual differences (the child's and the teacher's own), and a sense of humility. It seems to us that teacher selection must operate on the basis of a close study of each individual candidate. The teachers' colleges generally could do a job here by recognizing the need to select and train individuals specifically for the teaching of human-relations courses as a specialized field.

In our experience we have chosen our teachers in three ways. First, we have depended upon principals we knew personally whose judgment we trusted to indicate teachers. Second, we ourselves have come to know individual teachers and have approached school principals because such teachers were available in their schools and were capable of influencing the thinking and attitudes of the entire staff. Third, we have been fortunate in having a director of teacher personnel with a background of social work and vocational training who has been in complete sympathy with the program. He has selected teacher candidates, suggested individuals, and placed them in schools where such courses were needed and where it was felt that their presence would help to develop more understanding and tolerance on the part of the entire school staff.

One reason why we hesitate to set up definite standards for teacher selection is that we have often found excellent teachers in astounding ways. On the other hand, teachers who on the face of it should have been excellent proved to be serious disappointments. When we started out, teachers had to be persuaded to take on such courses. They were frankly skeptical and at times fearful. To-day teachers are coming forward and seeking to lead such courses. Psychiatry is certainly riding the crest of popular interest and undoubtedly some of the volunteers are motivated by this interest. It is doubly

important to screen each individual, particularly as to the motivation behind his interest.

Our teachers can be divided into three groups: first, the physical-education people who had been teaching health subjects; second, the people who had been in the Child Study Association groups under the auspices of the University of Chicago and the University of Maryland, now in their fifth year; and third, people with no specific training or experience in the area who were selected because various administrative and supervisory sources deemed them likely candidates.

By way of example, we should like to describe briefly several of our good teachers as well as several who did not work out so well. One of our most successful teachers is a physical-education man who was the greatly admired football coach. He began working in mental-hygiene courses with the twelfth-grade students, and became so interested in the possibilities of such courses that he asked to be relieved of coaching responsibilities and physical-education classes in order to give more time to his human-relations courses and the individual counseling that he was finding to be an outgrowth of them. In trying to understand why he has been so successful, we see three chief reasons: he was the boys' hero to start with; he is a very warm, sincere person in his daily relationships, with a direct, bluff type of honesty; he is mature enough to realize his own limitations and to seek help himself when he comes up against these.

The three problems of great concern to a high-school faculty are (1) grades, (2) drop-outs, (3) fraternities or closed social groups. This teacher's success is attested in the school's report of improvement in grades levels, a marked decrease in drop-outs, and a marked reduction in the number of students joining fraternities. The comment from the school authorities is that there has been a "marked improvement in the school's emotional tone."

In another junior and senior high school, the principal selected a teacher of mathematics to lead a group of eighth-grade students in discussions of their personal relationships. We were somewhat skeptical because the teacher had given no particular indication of skill or interest in this area. Certainly mathematics seemed far afield from human relations. The principal, however, was one whose estimate of his teachers was to be valued. Arrangements were made for this teacher

to give one hour a week to human relations, the other four to mathematics. Her classes have been outstandingly successful and her students have been eager to continue the discussions. She herself has reported that in the four hours devoted to mathematics, her students have done more and better work than they did previously in five hours.

Again, in trying to analyze the reasons for her success, we come up with the outstanding warmth of her relationships with young people. A second factor has been her ability to let the group talk without attempting to dominate it.

One more example of success is the rather retiring middle-aged teacher who, too, was nominated by her principal. She is motherly in her relationships with boys and girls and obviously feels more at ease with their groups. Her ability to sense the needs of the children, to develop these dynamically, and to carry them to a constructive, non-threatening level is unusual. She has kept rather full notes on classroom sessions which we have been able to review. One outstanding quality that she reveals in these is an excellent sense of humor and an ability to accept criticism of herself from her students. We should mention that this teacher has been active in the child-study groups. She certainly has given indications of excellent background training and personal growth as a result of this training.

A less successful individual was a teacher with a background of professional training and experience in social case-work and individual counseling. We had had considerable constructive contact with her in the study and treatment of individual cases in the psychiatric clinic. We were aware of a tendency on her part to become personally involved in the problems of the individuals being counseled by her, and yet she had an appreciation of motivations and a tolerance for individual differences. Hence, when a principal suggested her, we accepted her. The first indication of difficulties came when she reported that she had successfully forestalled even a chance comment on the social-hygiene aspects of boy-girl relationships. Now we all realize that in such discussions the mental- and social-hygiene angles are part of the total picture. It was pretty obvious that this avoiding had occurred not because the teen-age girls were not interested in discussing these subjects, but because she was unable to permit such discussions.

At one point the school authorities received a complaint from certain parents about the type of material discussed in a class. Investigation revealed an average teen-ager, a somewhat socially immature girl, coming from a highly protective home environment, who had been disturbed by some of the discussions of boy-girl relationships, not being ready for them. The teacher had been unaware of the girl's reaction or of any potential problems. The material discussed must be within the realm of the students' experience and immediate social readiness. The teacher, as the leader of the group, must be able to sense this and, in a positive, reassuring manner, keep the discussion within limits so as not to arouse anxiety or undue curiosity.

In another situation, a school principal requested that we start a program in his seventh and eighth grades. He was concerned about a series of boy-girl problems which had arisen in his school and felt that this was one way to handle the difficulties. He was an old-line educator with no dynamic understanding whatsoever. He had also shown weakness as an administrator in that he had a need to handle all details and to be informed about all the minutiæ in the life of the school. Since we were eager to begin our program in as many schools as possible, we agreed to initiate the courses here. The teacher suggested by the principal had some potentialities and we were hopeful. Shortly after he began his classes, however, a storm of parental protest arose and it became necessary to discontinue the program in this school.

We cite this example because it points up a basic point—that the principal of the school as well as the teacher must be considered. Furthermore, community readiness is a vital factor. Parental coöperation must be sought.

One more illustration is that of a man selected and placed by our director of teacher personnel in order to help in meeting a specific situation in a vocational junior high school. The children in this school are definitely limited. Their reading level is 2.3. Their age range is from fourteen to eighteen years. Intelligence levels are from the high 70's to an occasional above-average child. This school receives students who are misfits in every other area and who have been unable to make an adjustment. Many of them have displayed severe behavior problems.

The school had had an unfortunate city-wide reputation as a disciplinary institution. Some years ago the board of education had transferred to this school a principal who had an excellent record at an elementary school. It was felt that this principal could be helped by the proper person. The teacher chosen had had some of his training with Dr. Fritz Redl and his group in Detroit. He was keenly aware of the interplay among individuals in a group situation.

During his first year this teacher spent half of his time with two very slow, academically retarded classes, using "human relations" as one of his chief approaches, and devoted the other half to vocational guidance, working with individual children. In the classes he used the same group approach he had learned in dealing with delinquents in a camp for group treatment. This approach stresses individual differences, with particular emphasis on backgrounds as the basis for such differences, without becoming personal.

As a result of his efforts, this teacher has sold his principal completely on his classes. He is now doing a full-time counseling job, with no directions as to the use of his time. His work is individual counseling in the vocational and personal areas. Two other men teachers are continuing the human-relations classes. The first teacher was helpful in the choice and indoctrination of these two. The principal has been urging upon the school psychiatrist the extension and development of more classes. The principal and teachers report that the whole tone of the school has changed. Tardiness has dropped considerably. Paddlings have dropped off 75 per cent. As a direct result of these classes, the school program has been made more flexible so as to fit the needs, intellectual and personal, of individual students.

Having selected our teachers, our next problem is the training of those designated. When we began our twelfth-grade course in 1942, there were no teachers trained or experienced in this area. We were all feeling our way. We have stated that our basic theme has been the dynamic approach to human behavior. At the outset few materials usable in a public-school situation were available. We evolved our own outline on personality growth and used this as the basis for our discussions with the teachers. We met with the teachers to discuss and explain this material. Language had to be non-

technical and in terms of the teachers' daily experiences. Stimulus material was drawn from current events. For example, from the military situation, fears and anxieties were explained in terms of everyday happenings. Efforts were directed toward helping the teachers to feel safe with these materials, so that they might be able to carry them back to their students. After the teachers had met their classes, further meetings were held, so that experiences might be shared and materials brought out in classroom discussions interpreted in a dynamic way.

Several members of this first group developed into outstanding teachers able to serve as nuclei of other groups of teachers. They showed a great deal of growth in personal insight. Others developed sufficient awareness of their own needs to seek help from us on an individual basis. One teacher, for example, requested the opportunity to discuss the problems of his four-year-old son. He had had some awareness of the boy's difficulties, but previously had lacked the courage to do something about helping him.

When human-relations courses were initiated at ninth- and eighth- and seventh-grade levels, the teachers of these classes began to meet as a group at regular monthly intervals. Two teachers from the twelfth grade were the nucleus of the group. The purpose of these meetings was the exchanging and sharing of experiences and materials. Out of this mutual experience has come a reassurance and a poise for the individual that has enhanced the calm security with which each has met his student groups. The group has developed cohesiveness and unity. Individuals have gained security from the knowledge that other teachers face similar problems, have similar feelings of doubt and uncertainty. Many members of the group who at first had difficulty in verbalizing certain situations have begun to keep interesting and informative records on class discussions. After a year's experience in meeting together, this group is continuing and has added new teachers who are undertaking human-relations courses for the first time this year.

Recently human-relations classes have been initiated in some schools at the sixth-, fifth-, and fourth-grade levels. As it was felt that the problems and situations arising at these levels, as well as the materials, were different from those of

the upper grades, the teachers of these classes are meeting as a separate group. The nucleus of this group is a man teacher who had formerly met with the ninth-grade group, but who had already tried out such courses at the lower-grade levels. The schools in which courses have been started at the lower-grade levels are located for the most part in areas where the problems of living are pretty fundamental. Teachers must be realistic and practical in facing up to the personal relationships experienced by children living in these areas.

The teacher who served as the nucleus of this group had come into the upper-grade group the year before because he was eager for the psychiatric supervision available through these group meetings. Although he was teaching at a lower-grade level, he had made a real contribution to the group. He had had his students, a low-fifth and sixth-grade combination group, for a two-year period and had come into far more intimate contact with them than the other teachers had with theirs. He was much more conscious of the children's total way of living and of the need to gauge classroom instruction in all areas accordingly. It is of interest that other teachers in the group who had known him since the start of his career commented on the personal growth that he himself showed. He has become a softer person, tolerant of individual differences and keenly aware of the implications in his daily teaching. While other factors enter into the picture, undoubtedly participation in these groups and acceptance by the group have aided him.

Our next problem in the development of a mental-hygiene curriculum was the assembly of suitable teaching materials. We have already referred to our outline on personality growth, copies of which are available to those who may be interested. Since our earlier difficulties in obtaining dynamically oriented materials, much more has become available and some of it is excellent. For the twelfth grade, we have compiled the following reference list:

1. *Psychology for Living*—Sorenson and Malm
2. *People Are Important*—Ruch, Mackenzie, and McClean
3. *Personal Problems and Morale*—Geisel
4. *Learning to Live with Others*—Crow and Crow
5. *These Are Your Children*—Jenkins, Schacter, Bauer
6. *Personal Adjustment, Marriage, and Family Living*—Landis and Landis

7. *Better Ways of Growing Up*—Crawford and Woodward
8. *Life Adjustment booklets*—published by Science Research Associates
9. *Love at the Threshold*—Strain
10. *So Youth May Know*—Dickerson
11. *Your Marriage and Family Living*—Landis
12. Our own manual

The two books used most extensively in our own course outline are *People Are Important* and *Learning to Live With Others*. The Geisel book is closer to the old health approach. The two newest books on our list are, *These Are Your Children*, and *Personal Adjustment, Marriage, and Family Living*. The Crawford and Woodward book was written for twelfth-graders. However, in our experience, it has been more useful at the ninth-grade level. The Life Adjustment booklets, published by Science Research Associates, are excellent and liked by both teachers and students. These references, plus several additional ones on social hygiene, are read by the twelfth-grade students.

The list for the ninth, eighth, and seventh grades includes the following references:

1. Bibliography of the Child Study Groups
2. Life Adjustment booklets
3. *Child Psychology*—Leo Kanner
4. Discipline pamphlets—Fritz Redl
5. *Love Is Not Enough*—Bruno Bettelheim
6. *Human Relations in the Classroom*, Course I and Course II—H. Edmund Bullis

The child-study group has two large and inclusive sets of references which are standard for this group and are excellent. Their series of references are divided into areas—the physical area, the affectional area, the peer-culture area, and general references.

Some teachers have found *Better Ways of Growing Up*, by Crawford and Woodward, particularly valuable at the ninth-grade level. This book has an excellent bibliography, which has been used extensively. The Life Adjustment booklets have also been used extensively in the ninth grade. One teacher with a splendid background of experience and training in group treatment has stated that he found three references especially useful—Kanner's *Child Psychology*, Redl's pamphlets on "Discipline," and Bettelheim's *"Love Is Not Enough."*

The new teaching material for the ninth grade developed

by H. Edmund Bullis, of the Delaware State Society for Mental Hygiene, has been made available to the Cincinnati Board of Education.[1] This arrangement followed a conference between Mr. Bullis, the psychiatric personnel of Cincinnati schools, and one of the teachers. For teachers who are just undertaking human-relations courses and feeling somewhat uncertain of their approach, Mr. Bullis' published Courses I and II have been especially helpful.

We would like to comment briefly on the use made of such materials. The teachers who felt uncertain leaned heavily on the teaching materials, sometimes to the point of ignoring the group interest and following the written outline verbatim. As the teacher grew in personal security and self-assurance, he discarded such aids and relied more upon what the group brought out and upon his own skills in guiding the discussion.

One fact stands out in our experience—it is not the materials, but the personality of the teacher, that determines the success or failure of the course. We in the psychiatric group must realize that more and more fundamental materials are coming into the school curricula. Such materials are not limited to human-relations courses. They may appear in health courses, in social studies, in science, in arithmetic.

Recently a committee of our teachers has been considering the teaching of health in the primary grades. They have arrived at the point of view that the total child must be considered in all his daily experiences, at school, in the home, and in the neighborhood. They have recognized, too, that the teaching of health cannot be an isolated experience, but must be in terms meaningful to the child.

Many educators are not fully aware of the implications of these materials and the effects of such teaching upon individual children. That is the reason why we feel that the psychiatric group must ask what is being taught and how it is being taught. We feel further that such inquiries are most productive when a psychiatric unit is an integral part of a school system. As a part of the system, the psychiatric personnel are in a position to offer counseling and supervision to the teaching personnel in the building up of the curricula and their meanings.

Let me cite two teachers and how they used materials. The

[1] This material is soon to appear in book form.

first is the teacher already referred to in the account of our sixth-, fifth-, and fourth-grade teachers' discussion group. This teacher had a combined fifth-and-sixth-grade group of retarded children, economically and socially underprivileged. He taught a whole way of living, and he used his students' daily experiences for his materials. For example, he might have a project to study a neighborhood. He and his students would walk around that neighborhood, would seek out health and safety hazards, spot recreational needs and opportunities, discuss economic opportunities, all in terms of the individual child's needs.

The second case came to our attention when the mother of a ten-year-old boy discussed with us a problem arising from the classroom discussion of a teacher not a member of any of our groups. This teacher was obviously following the approved and accepted health manual of years standing, which discussed personality types. He had gone around the classroom and designated various children as types; one was "aggressive," another "domineering," and so on. This particular boy was told that he was the "shyest boy in the room." The boy was concerned and his mother disturbed. The boy was of better-than-average intelligence. Academically he had always been outstanding, sometimes too much so. He was compensating for his lack of physical skills. He was a large boy for his age, clumsy in the use of his body, and six months to a year behind other boys in the development of physical skills. As a result he had tended to withdraw from groups and had become something of a "lone wolf" on the playground. The parents were conscious of his needs and had been working with some degree of success to overcome his handicaps. Now the teacher had confirmed the boy's opinion and obviously was little aware of his needs.

Last year, at the conclusion of these courses, our teachers listed the topics that had been covered in their group discussions. In evaluating teaching materials, one fact was of interest. Regardless of the teacher's background, orientation, or references, the areas covered in all groups were just about the same. At the twelfth-grade level, both the teaching and the discussions are direct. As we go down to the lower-grade levels, the teaching must be in terms of the child's total experience and in whatever subject area this may be suitable.

Ever since our mental-hygiene curriculum was first initiated, we have been concerned about the individual who, as a result of the group discussions, feels a need for personal help and begins to look around for that help. There are many facets to this problem. In 1947, when we reported at a conference of the Orthopsychiatric Association on our mental-hygiene survey of high school seniors,[1] we mentioned how few of those students who had personal problems were known to community agencies outside of the school services. A sampling taken at that time of counselors' and deans' contacts with these same individuals strongly indicated that a student with such needs will tend to turn naturally to the school for help. This poses a problem for school authorities in providing the proper personnel and the time.

When the human-relations discussions were started, it was soon realized that there is a great difference between the skills of the good group-discussion leader and those of the individual therapist. The group leader is dealing with a number of "normal" individuals faced with the normal concerns of growing up. For the sake of the total group, discussion has to be kept on a general plane and not allowed to become personal. Cognizant of the group's interaction, the leader must be aware of the personalities of the individual members and note those who by their deviating responses show a need for personal help. Because of his rôle as the group leader, because of his status as a teacher with some authoritative background, there are limits to his personal relationships with such individuals. His rôle with the individual is primarily to guide the student to proper sources of help.

Teachers generally have been trained to deal with groups, not with individuals. There is usually a strong personal reason why they have gone into a group type of work. There is, of course, the exceptional individual who shows equal skill and ease in the group situation and in the more intense personal relationship with the individual. In our experiences, however, a teacher often enters into a personal relationship and, before he comprehends fully what is happening, finds himself in an intense emotional situation. Frequently there are outpourings and gropings from the students. The teacher may not know

[1] See Hertzman, *op. cit.*

how to handle the situation and sometimes becomes panicky. Psychiatric supervision and guidance at this point both for the teacher and for the student may be indicated.

But proper sources of help must be available. It is right here that a program of integrated pupil-personnel sources plays a vital part. We believe that our Cincinnati set-up, though not the only one in existence, is a good demonstration. Under one directing head are health and hygiene, psychological services, vocational counseling, home visiting and school social work, and the psychiatric unit. Our psychiatric social worker handles the intake for the unit. She assumes the responsibility not only of accepting or rejecting cases for the unit, but also of guiding those who are not accepted for the unit to other sources within the school set-up or within the community where they may receive help.

The experiences of one of our senior high schools is a good demonstration of how individuals in need of personal help can be guided in the proper direction. The boys who participated in the twelfth-grade course on "More Effective Living" were eager to carry further some of the ideas that had been discussed in one semester's class. Through the Hi-Y, they proposed an institute on personal problems. They sought the advice of the instructor, who was able to bring the boys' secretary of the Y, the school principal, and the psychiatrist into the planning group with the boys.

As a result of these joint efforts, a two-day institute on personal problems was held at the school in school time. Dr. and Mrs. Frank Liddle, of Indianapolis, were brought to Cincinnati to guide the institute. Dr. and Mrs. Liddle have had a wide experience throughout the Middle West in leading high-school students in discussions of personal problems. There were five student assemblies. Students were given the opportunity to raise personal questions, submitting these anonymously, in writing. Twenty-four hundred students turned in 2,643 questions. From long experience, Dr. and Mrs. Liddle were able to group these questions quickly for discussion from the auditorium stage with a give-and-take between students and discussants.

A group of eight outside counselors were assembled and time was set aside for individual interviews during the two days. Students were told that they might request individual time

with experts in various areas, such as social hygiene, vocational guidance, recreation and social activities (Y.M.C.A.), and psychiatric help. One of the outstanding facts that emerged from this institute experience was the desire of so-called normal students to seek help with personal problems when the chance is offered. As a result of this realization, arrangements were made for the same group of expert counselors to visit the school at monthly intervals for special individual contact with those students who sought it. Help beyond the resources of the school was thus offered.

It may be of interest, too, that in the psychiatrist's contacts he recognized all the students who sought time with him as young people whom he either had seen previously or about whom he had been consulted. The youngsters who had seen him before recognized him and appeared glad of the opportunity to renew contact.

Another outstanding fact of the institute was the apathetic attitude of the faculty aside from the few individual teachers directly involved. Dr. and Mrs. Liddle met with the faculty and discussed with them the material submitted by the students. This meeting developed into a rather strongly emotional experience for most of the faculty. They had little awareness of their students as total beings. The faculty reaction pointed up for us once again the tremendous importance of exercising care in the selection of teachers for these personal-problem discussions, as well as the urgent need for supervision and guidance of those chosen.

One final point on this institute concerns parental participation. We have already referred to the importance of community readiness for and parental awareness of what is going on in the classroom. Dr. and Mrs. Liddle met with the parents, too, and discussed with them the problems that are giving concern to their children. Too often at the high-school level, particularly in a large city high school, there is a chasm between school and parents. As a result of this institute meeting, the school made efforts to initiate a series of contacts with parents, especially of the ninth-grade students. When all the initiative came from the school, these meetings were not too successful. When a group of parents took over, however, results became more satisfactory.

It should be made clear that participation in group discus-

sions of personal problems and participation in an individual-therapy situation are not mutually exclusive or detrimental to the student who needs personal help. On the contrary, the two situations are highly compatible and may react very favorably upon each other.

Recently we initiated a human-relations course at the seventh-grade level in a certain school. The teacher nominated by the principal was a middle-aged woman with a known hypertension who had been in the school system for a long time. We were somewhat surprised at the principal's choice, but as she is an excellent principal with a great deal of understanding, we went ahead. After the course had been under way for a time, the school social worker approached us and wanted to know "what we had been doing" to her school. She then described how she had been trying for two years to work with a girl who was sullen, withdrawn, and unresponsive to her. Suddenly this girl seemed to open up, to want to discuss her situation. The worker was at a loss how to explain the change until she learned from the principal that the girl had been attending the human-relations discussions and was softening in the group experience under the motherliness of the teacher. The principal commented further that the teacher's attitude had been changing, too, as a result of her work with the class.

In 1946, a small, skinny, colored girl was referred to the psychiatric unit because of her vicious behavior in the classroom. She was having violent temper outbursts, during which her behavior was unpredictable and often dangerous to other children. Her parents were two very paranoid people who had received service from various community agencies over a period of time without being able to use such services constructively. As a matter of expediency rather than treatment, transfer of the girl to another school was suggested.

Recently we were asked to see the same girl again, not because of her old difficulty, but because she had some personal problems on which it was felt she needed help.

We were amazed to see a tall, strapping, well-developed girl in whom we sensed that certain fundamental emotional changes had taken place. Inquiry revealed that for two years the girl had been in the combined fifth-and-sixth grade to which we referred earlier in this paper. She had come into

the group belligerent and paranoid. Instead of being punished immediately for her outbursts, the teacher had calmly allowed her to give vent to her feelings and then had quietly suggested that she sit in the corner until she felt better. Later, the girl was able to thank the teacher for allowing her to express her feelings.

It was found that she had a good singing voice, and she was drawn into the group through group singing and dancing. Gradually she began to participate in group discussions. When she had first come into the group, a sociogram had indicated that nobody liked her, that they thought her dishonest, unpleasant, and difficult. Gradually she has acquired a few friends and some status in the group. Recently she was moved to a departmentalized school, where she became disturbed by the necessity for adjusting to a series of new teachers. She had progressed, but was still in need of the security and protection offered by the one teacher who taught a total program. Arrangements have now been made to place her in a special group where such a relationship may be resumed.

SUMMARY AND CONCLUSIONS

1. The development of a mental-hygiene curriculum is an essential phase of a total school mental-health program.

2. Educators are becoming increasingly aware of the importance of understanding personal relationships. They are not only developing the direct teaching of such relationships, but they are also finding ways and means of incorporating mental-hygiene materials in other parts of the school curriculum. Psychiatry must recognize this reality situation and be active in the picture, to integrate and evaluate such programs.

3. Problems encountered in setting up a mental-hygiene curriculum are (a) development of an understanding of such courses in school administrators, supervisors, and principals; (b) selection of suitable teachers; (c) the training and supervision of such teachers; (d) the assembly and use of suitable teaching materials; (e) the channeling of individuals in need of personal help to proper sources.

4. Our experiences have led us to believe that the working through of these problems is done most effectively when the psychiatric unit is an integral part of the public-school system.

5. The work with school personnel and the selection of

teachers is most productive when based on careful study of each individual involved.

6. The success or failure of the human-relations course is largely dependent upon the personality of the teacher who leads the course. There is a difference between the skills of the good group-discussion leader and the individual therapist. Occasionally an individual may be skilled in both areas.

7. The channeling of an individual from the group who seeks more personal help is a primary responsibility of the school and is best worked out through school sources.

8. Participation in group discussions of personal problems and individual therapy are not mutually exclusive; they may be supplementary or complementary.

9. At the upper grade levels, discussion of problems of living can be direct. The lower one proceeds in the grade level, the more it becomes necessary to teach from experience and to think and to teach in terms of the total child and his experiences at school, at home, and in the neighborhood.

THE MISUSE AND ABUSE OF CERTAIN MENTAL-HEALTH CONCEPTS *

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SINCE this series of talks is sponsored by a mental-health society, I approach my responsibility here with the same trepidation and concern that I experience whenever I plan to speak to an audience on mental health. Usually these talks and programs are sponsored by mental-health societies, and those of us who are active in these groups have begun to wonder, with critical self-questioning, how many of the benefits intended are achieved, and whether any harmful results accrue. Inevitably, many people interested in the mental-health movement and present at meetings are seeking solutions of their own problems. Consciously or unconsciously, there is the quest for an answer to one's own problems or to the problems of some one important to us. Together with this is the tendency to wish for rules and regulations—the right thing to do—in the vicissitudes of everyday living.

In this mood the speaker is viewed by the listener as an authority, and too often his comments are taken as absolute verities, rather than as a point of view. Often I have the feeling that, despite all protests to the contrary, there has been merely a subtle change in the labels of an old morality—that for some people the word, "sin," has been deleted and the word, "neurosis," substituted—and that really very little else has happened; the original attitudes remain.

Since the speaker is often a psychiatrist, it is assumed that he knows most, if not all, the things that one would like to know about mental health. In my opinion, the psychiatrist can qualify as an expert on mental ill health only. Unhappily, together with all his medical colleagues, a psychiatrist's training and subsequent practice have to do with people who are suffering. From the morbid, as has been the tradition, certain concepts, certain theories, certain hypotheses have been devel-

* A radio address delivered in Berkeley, California, December 3, 1951, under the auspices of the Alameda County Mental Health Society.

oped about the healthy and, more especially, about how to keep the individual healthy. As yet, physicians know very little about the well person. It is gratifying to know that medical schools are now beginning to focus on this problem; and that, in general, psychiatry is trying to do the same. A great deal of work remains, however, before any of us can function as health experts.

Suffice it to say that we psychiatrists are not what we are presumed to be. In addition to this rather obvious fact, I believe that we have been guilty, no matter how inadvertently, of promoting a number of misconceptions about mental health. With Professor Freud's discovery of the unconscious and his popularization of the instinctual energies, his postulate of conflict as the hub of any neurosis, and his accentuation of the rôle of frustration, many enthusiastic co-workers, disciples, and followers, through popular articles and speeches, have helped to foster certain of the misunderstandings that do exist. Out of the sheer exuberance of our insights into some of the factors that contribute to the development of neuroses, we have promoted these misunderstandings.

Accordingly, I ruminated on this talk that I was to give with this attitude: What harm can result, where might I be misunderstood, and, more seriously, what needless anxieties may I provoke? And ruminating thus, I decided that I might make a contribution by focusing on the damage already done. Hence my title, "The Misuse and Abuse of Certain Mental Health Concepts."

Prominent amongst these concepts is that of "permissiveness." "Be permissive," has become a slogan colored with the hue of virtue. A parent who is known as very permissive is viewed in some circles as walking with an especial halo. Most people will agree that no special praise is due any one for not stealing, or—to make it more ridiculous—for not murdering; yet we find it necessary to praise non-restrictive attitudes. This tendency suggests to me that what we praise is the *effort* that is implied in permissiveness. Because of this we need to question whether certain realities are not being sacrificed in the name of this virtue. Some people actually believe that they must never say, "no," to their child or horrible consequences, such as one of those neuroses, may result.

Only gross reality—an unmistakable hazard such as thrusting an arm into the cheery fire—will catapult some of these parents into restrictive action, together with that much maligned word, "no!" Of course, principles of distraction, of substitution of pleasant, non-dangerous activities, are well known and are of unquestionable value. But what possible gain is there in letting Junior jump on Daddy's chest or pull at Mother's skirt when neither is in the mood for it? In addition to being offered more mutually acceptable activities, it would seem that the child is entitled to know that there are certain activities that are unwelcome or that are unacceptable at certain times.

In the same category is the concept of "Never discipline." Of course punitive behavior of itself and by itself never helps. Too often punitive behavior results from the fear reactions in the parents occasioned by some threat. Johnny uses a vulgar word; the father fantasies his son developing into an uncouth hoodlum. His personal pride is threatened, and he punishes reflexly.

I recall an incident in a home in which even the word, "punish," had never been used. One day two of the children in this family arrived home from playing at a friend's house, and they had a grievance. They asked their mother, "Why is it that we never get punished?" The surprised mother inquired and learned that their friend had done something that was forbidden on a reality basis. They themselves had felt that it was unwise, and when the friend's mother had interrupted her child's play by saying calmly, "I will have to punish you for this," and then had put an end to his play, these children had felt that it was just—they even had felt relieved. In other words, the situation had been handled without fuss on a reality basis and a level quite comprehensible to them. Further, in this atmosphere they had felt a certain security and protection. Realities were sharply focused; they understood the adult and could agree with her. Of course this poses the question whether they missed this benign, yet firm protection in their own home.

Coupled with this is the notion, "Never show your child that you are angry," as if anger were an emotion to be exorcised from all humans. Of course this is unrealistic. We

all know that the capacity for anger is a necessary factor in human functioning, often a prerequisite for necessary action. Moreover, the child senses the hidden anger anyway and is puzzled by the duplicity of the adult. The naïve pattern of parents who retire to their own room to fight behind a locked door is usually frightening to the child, since, being deprived of the opportunity of witnessing what is going on, he fantasies aggressions that are more violent and destructive than the actualities could be. Given the opportunity of experiencing the other person's anger, the child is in a position to view it in perspective, to see the reality provocation and the response. Hence, he is in a position to adapt himself to this reality. Moreover, the opportunity to witness appropriate discharge of feeling, to experience it, and to survive, helps him to master this feeling within himself instead of fostering an unnecessary fear of it.

The concept of being "uninhibited" has led to exaggerated notions quite similar to those just mentioned. To take this concept in an absolute sense would imply that we do not admit inhibitions in our culture, which, of course, is not the truth. Every one is aware that an impulse-ridden person in our society gets hurt, often quite badly, and of course hurts others, often severely. There is a large gulf between feeling an impulse and discharging it. Certainly, certain actions should be suppressed.

In keeping with this "Be uninhibited" philosophy is the admonition, "Let out your aggressions," or, "Be aggressive." In extreme situations, we have the doting mother taking inventory of property damage, and saying cheerily, "Just an aggressive little boy. I prefer him that way to the timid type." It may not occur to her that Junior hacks away at her coffee table because he would welcome a little aggression from her in the way of setting some limits to his behavior and providing some leadership *re* things that can be done and that are fun. Healthy aggressions usually discharge themselves in appropriate ways and need not be confused with wanton destruction of people or things.

Of course, this brings in the question of *frustrations*. The misuse of this concept is astounding. Some people believe that frustrations are of themselves harmful. Actually, it is inconceivable that growth should take place without the mas-

tering of frustrations. Yet many parents devote their lives to the principle that they must spare their child all possible frustration. No one needs extras in the way of frustration—everyday living brings an ample quota—but the intervention of parents to spare their child these experiences is to rob him of the opportunity to master them. Consequently, his capacity to tolerate tension is not developed, and any frustration provokes a reaction out of keeping with the intensity of the stimulus. I doubt that any one would claim that the toddler is helped to master the involved mechanics of walking by having an adult carry him around all day lest he fall in attempting to walk. The very fall of the toddler, his awareness that he can stand it, and his growing ability to avoid it are integral parts of learning to walk. So it is with all the real frustrations of everyday life.

Thus far my comments have included child-parent relationships as examples. This applies, of course, to all human interactions. Because the child is in a sense a new person, much of what he does and what happens to him serves admirably for purposes of illustration. Yet there is the notion amongst some devoted parents that their child must come first, no matter what the circumstances. If this is taken literally, it would suggest that more value is invested in the child than in the self, and we should be led to wonder why this is. If it is not taken literally, then there is something artificial about it, and again there would be cause for wonder.

I will avoid speculation on these factors since they are not specially pertinent to this paper. However, the reality of the situation is that the adult is who he is, and the child is a different person, with his own special needs and interests. Included in these is his need to measure himself against the parent, as a model or ideal, to gain a reality perspective of his powers *vis-à-vis* the parent, of the things he can achieve or hope to achieve, as evidenced by the skills or capacities of the parent. With the growing awareness of similarities and differences—but always with the reality awareness of himself and the parent as separate persons, each with his inherent rights and privileges—the child is helped to accommodate himself to his realities throughout the shifts and change of growth.

The abuse of certain mental-health concepts exists in areas

quite apart from child-parent relationships. The misuse of the concept, "psychosomatic," may well serve as an example of this. There is some room for concern about the glibness with which many people toss off this cliché, "psychosomatic," irrespective of pathology.

In the first place, the term is very unsatisfactory and unfortunately it has had publicity in the press and from the lectern as if it were a new discovery. Any one who is ill experiences his illness, no matter of what kind, in accordance with his personality functioning. Accordingly, every one reacts psychically to somatic disturbances. Indeed, all illnesses may be said to be psychosomatic.

Too often enthusiasts are inclined to show their awareness of this by minimizing the reality of the reaction, as if to imply that "psychosomatic" means trivial or unimportant. Of course this betrays improper understanding of what is meant by the term clinically. Generally, it is used where the emotional factors play a leading or precipitating rôle in the development of the reaction. This could well indicate that the emotional factors require some amelioration, or alteration. Merely minimizing them does not effect this. Nor, on the other hand, is an overemphasis on the emotional factor or factors present of any help when actual life-saving measures may be needed.

It is generally accepted that in cases of peptic ulcers, certain emotional factors have played a sizable rôle in the causation of the disease. I doubt that any one would forego the requisite surgery, when there has been a rupture of an ulcer, merely because the emotional factors present are obvious. And yet there is still this tendency toward dualism, the idea that things are either of the soma or of the psyche, even where the conjoining word, "psychosomatic," is used. In effect, many people have clutched this word as a more palatable synonym for the word, "neurotic"; but it is looked upon with the same pessimism and scorn that were once reserved for the term, "neurotic." Unfortunately, this is done by professional and lay groups alike, representing very little more than semantic gymnastics without true insight, and at times without any measure of real understanding.

Then there are the clichés that have developed about the

concept of compulsiveness. If one likes a neat home, a well-ordered garden, a certain routine of living, a preference for what may be termed, "gracious living," there is often a tendency to raise the bugaboo, "Maybe this shows I am compulsive?" This has become part of the new vernacular of the old morality, the substitution of "compulsive" for terms such as "bad" or "evil." When one has developed a useful and efficient pattern for doing things, then the question, "Am I getting rigid about this?" is raised with the very same implications. Then, of course, among the neo-sophisticates, when a person likes to eat or enjoys conversation, the knowing comment is made, with or without checking, "He is quite oral, isn't he?"

These examples could be multiplied endlessly, all illustrating the same point—namely, that all persons have these various tendencies to a greater or lesser degree. What is of concern to any individual really is whether he is the victim or the master of these traits. Their mere existence and the proportions in which they exist lead specifically to the nature and form of that individual's functioning. To draw unwarranted conclusions, like those above, is a definite misuse of these concepts.

Ever since we have come to realize how much our functioning is the result of interactions between the instinctual life and the censorship mechanisms in each person, parents have become Public Enemy No. 1. Because it was discovered that censorship mechanisms are evolved from parental prohibitions and restrictions and integrated into the functioning self as a powerful force, many have felt that neuroses are the consequence of too harsh and too punitive a censorship. Accordingly, the original models are blamed, and there has been a field day in directing censure against parents. Consequently, we find to-day that conscientious parents are needlessly anxious and apprehensive about the horrible things that they are doing to their children, be these consciously or unconsciously determined. Often they tend to treat their children as poor victims of the parental not knowing, not doing what is right. It is as if a new slogan had been formulated, "Beware the Parent!"

True, there are some recent shifts of blame to other shoul-

ders—namely, those of the teacher. But conspicuous in all of this is the perplexed brow of the mental-health mother asking with a sense of outrage, "What can I do with Father?" The function of Father is a topic that can be discussed with profit by any persons interested in family living. I believe that much of the complaint about Father has to do with the wish for established, predictable, and, of course, socially acceptable patterns. To-day, with a tremendous shift in socio-cultural patterns, traditional modes of behavior have become outdated, but newer modes have not jelled as yet. In this era of flux, there is a general uncertainty, coupled at times with dissatisfaction, with the contribution of Father. The shifts *re* mother and her function are apparent at the same time, but her function has strong biological roots which provide an instinctual base from which secondary elaborations develop. The fathering function does not have this same anchorage, yet there are strong biological roots in terms of masculine-feminine functions.

Numerous misconceptions about permissiveness, discipline, frustration avoidance, all have their reflections in the hesitancies and indecisiveness as to the functioning of fathers these days. Yet certainly one cannot believe that a strong, confident, interested, participating man, offering leadership and protection to his family, is ever a dispensable factor. So often mothers are busy indoctrinating fathers with what they believe are good mental-health principles. In former days it was true that fathers looked upon child-rearing as woman's work, but to-day we see an increasing readiness on the part of fathers to inform themselves on the nuances and complexities of age-period development. Nevertheless, some do resist and do use this arena for the discharge of grievances and resentments against wives by sabotaging any project that the mother may attempt. The converse is equally true—many enlightened mothers choose this arena to discharge pent-up hostilities against Father that really pertain to his function as husband.

Common in the present-day family is the scene at the dinner table. The mother is prone to complain that within the space of one meal the father has wrecked all the good work she has accomplished through diligence, understanding, patience, and whatnot over the entire day. A frequent complaint is that

Father demands that the children improve their manners. Often this is reported by the mother in a tone of ridicule, if not of disgust, as if there were something improper about any emphasis on the accepted patterns of behavior that are called "good manners." To expect good manners in eating from a two-year-old, who is testing his or her flinging power, is to ignore the reality of that child's development. Equally, we can say that to permit this behavior to continue unmodified in a six- or eight-year-old because he is only a child, is to ignore his reality. Certainly we must be cognizant of what Dr. Spitz calls the "age-adequate response." Parental responsibility relates to the age-adequate stimulus.

In any case, where the affection of the father is genuine and unquestioned, his tendency to be a bit severe or gruff need not be viewed as a calamitous factor; nor need he, in turn, become overly concerned that his wife shows occasional tendencies to be overindulgent to their youngster. Where the child feels an adequacy of affection from his parents, neither the hardness of the father nor the softness of the mother will harm him in any serious way. As long as he has a sufficiency of elbow room, his own energies will promote the requisite growth in the direction of health. The overly troubled mother, concerned that Father has spoiled her good work, indicates some insecurity about the total relationship of the individual family components. If her work is really good, Father cannot ruin it in one session or by one explosion.

Under the name of "freedom," there is a tendency in some relationships for one person to leave all the expressing of preferences and needs to the other person, forgetting, it would seem, that the relationship is a two-way street, and that the other person expects the same freedom of expression from his or her mate. Occasionally husbands so doting as to refrain from mentioning any of their preferences or inclinations, playing the rôle of "Good Joe" with a heavy hand, are real problems for their mates. This covers a gamit of experiences, ranging from favored foods on the menu, through preferred recreations, to the more serious question of whether he does or does not want a baby.

This attitude of anything-you-say, or we-will-do-what-you-want can hardly be mistaken for a "free atmosphere." Each

person in a relationship should indicate his or her own attitudes, preferences, choices. Only then, through a process of adaptation and compromise, will mutually pleasurable activity follow.

Interspersed in these pseudo-giving patterns, which often hide mere passivity, is a pattern of pseudo-altruism, also masquerading under the title of letting the other person feel free —getting the other person to express his wants. One mother reported that before retiring one night her daughter asked, "Mommy, will you read to me to-night?" and Mother replied, "I will if you want me to, dear." Whereupon her youngster said in exasperation, "Mommy, when are you going to read to me because *you* want to?" The same question may be addressed by husbands to wives, and vice versa, in numerous life situations.

In keeping with this it becomes necessary to remind parents that it is very fine, very commendable, to have children grow up with a sense of free choice wherever possible; but it is equally important that the parents exercise this same right. It is helpful when all elements in the family have similar, if not the same, privileges. We have been stressing this for children, but it seems that not enough stress has been put on the fact that parents are people, too—people with impulses, with needs that seek gratification. Certainly children can appreciate this, and not only appreciate it, but thrive because of the consistency of the patterning of behavior throughout the family, the willingness to let the child know that the parent has moods that shift; that when the parent is tired, certain activities are unwelcome, though they may be very enjoyable at other times and under other circumstances; that parents do make mistakes and are willing to admit them as well as to make amends.

With our growing appreciation of geriatrics as a developing specialty in medicine, the behavioral aspects of older people begin to require our attention. The middle generation might pause and consider whether the same courtesies are available to the older generation as are offered to the younger. The grandparents have their own needs and impulses as people, colored and complicated by the circumstances of the past and present living. Do we view them in terms of age-

adequate responses or is there a tendency to make unrealistic and unwarranted demands that they adapt to us? Despite the tendency in some quarters to blanket everything the grandparents did as inadequate if not harmful, less biased scrutiny reveals wonderful intuitions on the part of some of them. Many who were free enough to react intuitively did provide the very securities we seek to-day. Most of them did what they could.

They did not know about the unconscious; they did not know how often people are prisoners of overly harsh, and at times tyrannical, censorship mechanisms. We have the advantage of this knowledge and have been very busy freeing the prisoners by reducing the harshness of these censorship mechanisms. In many instances, misconceptions arose because certain enthusiasts were ready to abolish all censorship, ignoring the fact that unbridled and unrestrained impulses do not make for happiness, but for chaos. We do need our censorship mechanisms to modify our instinctual energies, so that our resultant functioning may be appropriate to the realities of our life situation. Wherever and whenever life situations are themselves unhealthy, the virile functioning of the healthy person puts him in a favored position to effect desired change, be it in culture, in social mores, or in the very economy of our living.

LEARNING SELF AND SOCIAL ADJUSTMENTS THROUGH SMALL-GROUP DISCUSSION

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CAN preventive mental hygiene be taught effectively through small-group discussion in high schools and colleges? Since group-discussion therapy has proved to be beneficial as a treatment method for the social reëducation of mental patients and juvenile delinquents,[1] could a similar method be used to give so-called normal individuals better understanding of themselves and others?

The writer attempted to answer these questions through an exploratory investigation of multiple counseling among high-school, university, and adult students. Eight discussion groups were formed of students who were interested in gaining better self-understanding and social skills. Self-appraisals and personality inventories were written by the students in conjunction with the group discussions. The writer served as moderator and resource adviser in the discussion meetings. She held counseling interviews at the end of the project with the individual participants.

A successful college experiment in preventive mental hygiene was reported recently by Professor Torrance,[2] of the Kansas State College of Agriculture and Applied Science. In his course, students applied the principles of mental health in solving their problems of self and social adjustment. A modified type of discussion therapy was used. The investigation described herein had similar purposes, but the activity was called "discussion for better understanding of one's self and others." An inductive method of discovering mental-health principles was used. Thus the discussions revolved about the individual viewpoints of group members concerning

[1] See *Group Psychotherapy: A Symposium*, edited by J. L. Moreno (New York: Beacon House, 1945). See also *Creative Group Education*, by S. R. Slavson (New York: Association Press, 1948).

[2] See "Getting Mental Hygiene Practices into Action Through a College Class," by Paul Torrance. MENTAL HYGIENE, Vol. 35, pp. 88–95, January, 1951.

a number of personal and social adjustment problems. Discussion topics were introduced by sociodramas or informational talks. The stream of discussion was allowed to follow any direction the members desired and there was no attempt to solve group problems or to reach final conclusions at the end of a discussion hour.

According to Dr. Slavson, this type of free discussion in a permissive atmosphere tends to enhance feelings of self-esteem and self-worth. He says that many individuals who believed themselves failures in other relationships grow convinced of their value, their abilities, and their strengths.[1]

In this investigation students were urged to act the way they felt, and competition was completely eliminated because there were no grades or prizes to be won. Emphasis was placed upon respect for individual differences within the group, and "talking out" feelings of irritation or hostility was encouraged. Usually the discussions were leaderless and participants volunteered to speak, instead of being called upon for their opinions. The writer served in the capacity of a neutral group therapist or moderator in most meetings.

Each group was composed of from eight to ten members, including, wherever possible, equal numbers of male and female participants. There were eight groups in all, with a total of seventy students on the three maturity levels. The general purpose of the adult participants was to learn more about motivational patterns among school children, for they were school-teachers, administrators, or athletic coaches. Many of them, however, felt a need for better understanding of themselves as persons with self or social adjustment problems. The university students ranged in age from nineteen to twenty-six years and were enrolled in the school of education. They gave a variety of reasons for electing the group-discussion project, including enjoyment of discussion, lack of confidence in speaking before groups, inner conflicts, or uncertainty concerned with social adjustments, vocational choices, and so on. The high-school students were seniors, ranging in age from sixteen to nineteen. They were particularly interested in personality growth, vocational guidance, and social skills.

[1] See "Group Bases for Mental Health," by S. R. Slavson. MENTAL HYGIENE, Vol. 33, pp. 280–92, April, 1949.

The adult groups engaged in six discussion sessions, extending over a three-week period. The university and high-school groups engaged in seventeen discussion sessions, extending over a two-to-three-month period. Discussion topics centered on behavior analysis in terms of individual differences and human relationships. Personal and group prejudices were freely discussed. Each student was encouraged to express his viewpoints and feelings, which were based upon personal experience. The catharsis, or talking-out process before a sympathetic audience, was the outstanding feature of the discussion activity for the majority of students in each group. And the griping or blowing off of steam enjoyed by individual participants was not limited to the teen-agers. For example, teachers in several of the adult groups delighted in "digging" at school administrator members. Strong opinions were expressed concerning poor school management, excessive teaching loads, inadequate salaries, and so on.

Discussion topics were designed to fit the maturity level and common interests of each group. Examples of questions are given below:

1. Why does one like or dislike certain people or groups?
2. What is emotional maturity? A well-balanced life? A well-adjusted person?
3. What is "a feeling of security"? How do we get it; keep it; lose it?
4. Which of the four basic drives (to live, to love, to belong, to be recognized) is most important to you? What would you like to be, ten or fifteen years from now?
5. Do personality differences make for success or failure on a job? Are there certain personality types for certain types of occupation?
6. Which is more important in molding your personality: heredity or environment? Is personality modifiable?
7. Why is the United States so hated by other nations when we have done so much for these nations?
8. What can you as an individual do about racial and religious prejudices?
9. Should an American soldier marry a Korean girl? Are mixed marriages successful?
10. Why do some people like to get drunk? Make nuisances of themselves? How do you explain be-boppers and certain types of gangs?
11. What are the common defense mechanisms we all use—to make excuses or alibis, cover up our feelings, such as "sour grapes, sweet lemons"?
12. What are the parts of social competence? Can skill in getting along well with people be learned? If so, how?

In addition to the group discussions, all participants wrote self-appraisals and personality inventories. Also, they evaluated their fellow members at the beginning and the end of the project by means of a sociogram. In this they listed first, second, and third choices in a number of categories, such as attractive appearance, friendliness, leadership quality, brain power.

Two counseling interviews were held with each university and high-school student in order to interpret test and sociogram results and behavior observations and to secure from each participant his opinion of the worth of the project. In many cases the student asked for counseling aid, so that part of the first interview and the entire second interview were devoted to the counseling process. Since the second counseling interview was held one to three months after the end of the project, "simmering" effects of the project could be assessed.

A questionnaire was mailed to the adult students in place of the second counseling interview. This was sent four to ten months after the project ended, and 83 per cent of the questionnaires were returned.

The enthusiasm of the seventy participants was expressed verbally in the counseling interviews, and also in written evaluations. According to the participants, the group experience resulted in changed attitudes and improved behavior patterns for many of them. Healthy personality growth appeared to be influenced by the group experience, especially during the "simmering" period after the discussions had ended. Proof that the project had been a meaningful learning experience appeared in evidence that many of the students had consciously applied principles of self-social adjustment in their daily lives. Many of them gained confidence and skill in expressing themselves verbally before a group. Many indicated improved attitudes toward certain persons or groups which resulted in getting along better with them. All the participants said that the group experience had been enjoyable, satisfying, or helpful.

A comparison of student reactions to the group experience among adult, university, and high-school members shows many common elements of therapy and learning in the field of preventive mental hygiene. Examples of statements made

by students in the counseling interviews or written evaluations follow:

Statements of Adult Participants

"It helped to explain why I do some of the things I do—to clarify or reëvaluate my personality traits."

"I got reassurance that others have similar problems and difficulties."

"It increased my skill in expressing views on a subject, gave me more self-confidence in group discussion."

"It improved my ability to adjust to other people."

"Reasons for racial prejudices were made clear."

"Now I realize that first impressions may be quite wrong."

"I understand better the behavior causes in problem children, and can work out better methods in handling them."

Statements of University Students

"It confirmed my hopes (fears) regarding certain personal traits."

"It helped me in my vocational choice."

"Talking out problems and blowing off steam made me feel better."

"It made me want to improve my personal weaknesses."

"Acceptance by the group gave me reassurance and satisfaction."

"I learned much more than in a classroom because my mind had to work all the time—applying the principles learned, etc."

"It increased my skill in organizing my thoughts and expressing views on a subject."

"It helped me to understand and to get along better with [some person or group]."

"Acting in sociodramas gave satisfaction. It made the problem more real—stimulated thinking because it defined the problem to be discussed."

Statements of High-School Students

"It is good to know that others have worries and problems like you."

"I see now that in comparison with the others I am too (moody, pessimistic, self-centered, forward, lacking in an aim in life, etc.)."

"I could feel just like the ones in the sociodramas—could see both points of view."

"I'll try harder to like people and act better (in groups, at home, etc.)."

"Arguing and talking was fun."

"Before this I couldn't stand up in English class and give book reports. Now I can, and have given two in succession."

"I have learned not to have such strong prejudices (racial, religious, or political)."

In the months following participation in the discussions, many of the students and teachers reported improvement in self or social adjustments. Thus one teacher wrote:

"I gained greater tolerance of colored people from Mr. W.'s explanation of the Negro point of view. . . . I gained an appreciation of the use of humor from Mr. O."

Another teacher whose difficulty was shyness and lack of self-confidence wrote:

> "I have increased self-confidence as a result of confirmation of hopes . . . am able to express my opinions more freely with less fear of criticism . . . I have joined social organizations wherein opportunities to make acquaintances are many."

One of the university students, who joined the discussion group because of his shyness in expressing himself before a group, not only improved in verbal expression, but also gained insight into reasons for a serious inferiority complex. During the months that followed, the support given him by the group and the counselor proved influential in his freeing himself from parental domination. Also, he was able to perform creditably as a substitute teacher during the absence of his critic teacher. He believed that the improvement in his self-confidence and leadership ability had been aided by the discussion-group experience.

One of the high-school-senior boys had been seriously maladjusted at home and at school during the first three years in high school. He was an isolate, disliked by his peer group. He had no friends and did not date. Poor grades had resulted not from a lack of scholastic aptitude, but from habits of daydreaming, reading books on abnormal psychology, worrying about his normalcy. In the first meetings of the Personology Club (this name was given to the discussion group), he was heartily disliked by the other members because he acted in a superior or insulting manner. He contradicted and interrupted every one, including the counselor. During the seventeen meetings he saw the error of his ways, became a better listener and a more coöperative, friendly participant. The fact that his fellow discussants grew to like him contributed greatly to his awareness of personality weaknesses that could be modified. Subsequently he left school to join the navy. The second counseling interview, held during his furlough from boots camp, revealed a good carry-over of his new resolution to "learn how to get along with people." He believed that his success in group living at camp had been aided by the group-discussion experience.

The conclusion is that small-group discussion can be an effective learning medium in preventive mental hygiene when it is focused on needs and interests of individual group members. The activity encourages objective analysis of personal strengths and weaknesses. It shows the participants ways to

apply principles of social adjustment in their daily lives. It gives them practice in social skills and harmonious group membership, even when controversial subjects and differences of opinion are involved.

This conclusion may be true only for students who *want* and *need* better understanding of themselves and others, but since many students seek counseling aid in solving their personal and social problems, school programs might do well to include group-discussion projects focused on preventive mental-hygiene principles.

Application of the small-group-discussion method described above is now in progress at the Student Counseling Center of the University of Wisconsin. During the academic year 1951–52, thirty student counselees engaged in this activity for the purpose of improving their self-understanding and their understanding of others. Ten students were under psychiatric treatment and twenty students were counselees at the center who volunteered for the group activity in addition to individual counseling contacts. Thus the discussion sessions were an auxiliary activity, coördinated with individual counseling, which was carried on simultaneously.

The psychiatrists and counselors reported that the clients who were regular in attendance at the weekly discussion sessions gained insight, and improved attitudes and behavior patterns. The student participants evaluated the group experience in similar fashion to those in the initial investigation —namely, they enjoyed the activity and gained in understanding of self and others. There was a carry-over into daily-life adjustments which the students attributed at least in part to the group experience.

Although the small-group-discussion activity was not publicized, other students heard about it from friends or counseling-center contacts and requested membership in a group. Thus this activity appears to have won a place among the services of the university counseling center. Students who have *felt needs* in areas of personality growth apparently use small-group discussion as a learning climate, when it is coördinated with individual counseling by competent personnel.

MENTAL-HYGIENE CONTRIBUTIONS TO THE RESETTLEMENT OF IMMIGRANTS IN ISRAEL *

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THIS paper is based on four years of mental-hygiene experience in Israel with both adult and child immigrants. Israel to-day has a population of one and a half million Jews, of whom over 700,000 have immigrated since the reëstablishment of the state in May, 1948. Thus problems of immigrants in all their manifestations color every aspect of the social, economic, and cultural life of the country, and represent a tremendous challenge to the mental-health worker.

The immigrant to Israel, as to any country, loses many of the external social supports of his ego structure and at the same time is exposed to increased stress. The confidence he previously derived from familiarity with the surrounding way of life and identifications with family, neighborhood, and work and ethnic groups gives way to anxieties and insecurity, linked to his unfamiliarity and lack of identification with the new environment. The strange language and cultural habits, the new manners and values, the uncertainty as to housing, work, and political status, and often the separation from family and friends, all increase the strain. Despite the fact that, as Jews, the immigrants have a common general historical background, religion, and fundamental tradition, they originate from over sixty different countries, so that interethnic frictions and tensions add a further load to the pressures against which they must stand firm.

One problem that is less obvious in Israel than in other countries of immigration is the ambivalent attitude of the stable population toward the newcomers. This means that at best they may be suffered to come in, and at worst may be

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actively persecuted and segregated from the general life of the country. In Israel the whole essence of the state is based on the project of the ingathering of the exiles, and the negative aspects of this primitive ambivalence to the stranger are largely unconscious. They are, nevertheless, clearly perceived by the immigrants, who are hypersensitive in this respect.

Most immigrants arrive in a condition of weakened ego resistance because of past sufferings. To Israel, as to other countries, they come after cruel persecution in ghettos and concentration camps, and often after years of wanderings as displaced persons searching for a haven. This haven has usually become an object of wish-fulfilling dreams and fantasies. When the harsh realities of the new country splinter these utopian ideas of solace in an all-comforting, all-gratifying refuge, where human relationships are perfect, this is often the cruelest blow for them to withstand.

This combination of loss of the external supports on which the ego relies for much of its strength, together with the tremendous increase in the strains to which it is subjected and the emotional demands that it is called upon to master, explain many of the psychopathological manifestations so common among immigrants.

Most immigrants show some signs of absolute or relative weakness of ego strength and capacity. They suffer from increased general anxiety and feelings of insecurity, and there is a lowering of the previous efficiency of the controlling and integrative functions of their personalities. Regression to more infantile methods of reaction and defenses against anxiety is common, and this often manifests itself as an increased need for dependence. Quite typical is an increased sensitivity to stimulation and a lowered tolerance of frustration, to which the immigrants react either by undue aggressiveness or by withdrawal. There is usually a loss of security in interpersonal relationships, which often has an all-or-none character. After being hurt once or twice on arrival, they retire into a corner of the social field and behave rather like new hens in a coop, which retreat into a corner and peck any old-timer that comes near. Like the new hens, it takes quite a time before they gain sufficient confidence to come out of their corner into the general social-life field. This withdrawal period is lengthened by the feeling that to come out into the open even a little

way is just as dangerous as to leave their safe corner altogether.

It is because these first steps into the new relationships seem so overwhelmingly threatening that the process of adaptation is often so long in starting. Once it does begin, the immigrant can learn by experience, and if this is not too traumatic, he gains the confidence to move more freely into relationships with the people of the country. But even immigrants who adapt most favorably to their new surroundings seem to grow an artificial shell to their personalities. They behave for years in a harder and more aggressive way, and have a greater tendency to paranoid ways of reacting than formerly.

During the process of adaptation to the new country, many immigrants manifest symptoms of acute or chronic breakdown which are, of course, dependent not only on the general factors of ego weakening and strain, but also on the previous constitution and personality structure of the individual. Like war neuroses, which these breakdowns resemble in many ways, their incidence in any group of immigrants is correlated with the level of morale of that group, as well as with its specific history. Among the typical syndromes which have appeared among immigrants to Israel have been the following:

1. *Irritable aggressiveness,* which is often explosive as a reaction to minor frustrations.
2. *Withdrawal states,* in which the individual becomes apathetic and quite dependent on others and in which there is generalized emotional blunting.
3. *Paranoid reactions,* ranging from the fairly common excessive demands for "rights" and the displacement of hostility felt toward former persecutors onto those at present taking care of the immigrants, in all gradations to frank paranoid psychoses. The latter often start with dramatic suddenness, but are usually of short duration.
4. *Traumatic neuroses and exhaustion states,* very similar to typical war neuroses.
5. *Depressive reactions,* which are often secondary to withdrawal or traumatic states.
6. *Regressive reactions,* which have been seen mainly in immigrants from certain Oriental countries. In these

people, after a period of strain, there occurs an acute ego breakdown with regression to an early infantile level of functioning. The clinical picture resembles schizophrenia, but delusions and hallucinations are rare, and the condition clears up in three to four weeks with removal from the stress situation and ordinary general nursing care and attention.

7. *Psychoneuroses,* the type of which depends on the individual's previous personality structure and elective defense mechanisms. They have proved rarer than would perhaps have been expected in situations where the healthier ego defenses have been so weakened by increased strain and loss of support.
8. *Psychoses* other than reactive depressions and paranoid states have not appeared with any increased incidence over what would be usual in a stable population.

This brief summary of the emotional problems of immigrants serves to introduce the main topic of this paper—namely, what can be learned from experience in Israel regarding the possible contribution of mental-health workers toward helping immigrants adapt to their new surroundings with minimum damage to their mental health.

It rapidly becomes clear that, with such a vast wave of immigration and with a limited number of trained psychological workers, it is impossible to make any major contribution in the form of individual psychotherapy or case-work. This does not mean that clinics should not be set up wherever possible in circumscribed parts of the field. Here the classical team of psychiatrist, psychologist, and psychiatric social worker can provide a therapeutic service for individual immigrants who desire help, and can assist those who are referred by other professional workers for consultation in regard to psychiatric diagnosis or guidance. The primary goal of such clinics, however, should be envisaged in terms of research into emotional aspects of the adaptation process under prevailing reality conditions, and not in terms of treatment of individuals, whose number can be only an insignificant proportion of those in need. Equally important, such a unit can enrich the skills of other professional workers dealing with immigrants, and can provide postgraduate institutes and train-

ing courses to sensitize them to the human problems of their clients.

The mere existence of the psychiatric team stimulates a demand from other professional workers for further education, which in addition to being formalized in courses, can be effectively carried out in relation to the cases that they refer for psychiatric or psychological appraisal. This function of the psychiatric units is organized along lines similar to those worked out in traditional mental-hygiene-oriented child-guidance clinics. The resemblance lies also in their treatment of the individual immigrant referred for help, who is handled by a multidisciplined approach which stresses social, cultural, and economic adaptation rather than deep psychotherapy for neurotic conflicts. Individual psychiatric treatment should also be available if possible in small-scale inpatient units. Here the acute breakdowns are dealt with by rapid intensive methods similar to those used in army psychiatric units, and the patients are quickly passed over for brisk rehabilitation. Experience has shown that in a small open psychiatric ward in a general hospital, the average inpatient stay could be kept down to seventeen days, if maximum use was made of physical therapy, group-psychotherapeutic techniques, and individual case-work methods, including intensive after-care.

In considering the rôle of mental-health workers amongst the immigrants, it must be realized that the main task of rehabilitation is carried out by administrative organs of the government or immigrant organizations such as the Jewish Agency for Israel. The provision of housing, work, schools, general medical and social services, and the policy of direction of the immigrants to special areas of the country and their incorporation in its political life are the main factors that will determine how smoothly and how quickly the newcomers will be able to acculturate and achieve the support of identifications with their new surroundings.

Since it is obvious that the policy pursued by these executive bodies and the main details of its practical implementation will have a major effect on the ease with which the immigrants will adapt, it is clear that mental-health workers should attempt to influence these processes. By acting as expert consultants, they can make maximum use of the knowledge already acquired and of the increased insight developed as a result

of continuing research. The latter will be really worth while from a practical point of view only if it can be constantly fed back to the community in small doses through regular consultations with the administration.

The World Health Organization and the World Federation for Mental Health have established the precedent for such consultations at top international levels. In some countries the utilization of psychiatrists as expert advisers has been a feature of army organization, but in Israel the idea is new, and lines of action and techniques of communication are still in the early stages of being worked out.

The last three years have shown some advance in this direction. There is increasing awareness in government and Jewish-Agency executive circles of the possible value of consultations with mental-health experts, and certain important changes of policy have been brought about partly as a result of this.

One important example is that the huge immigrant camps in which newcomers used to spend many months in large barrack huts, in idleness and increasing apathy, have now been replaced by small work camps scattered over the country. Now, the family unit is accepted as the basis for housing provision in small huts, and constructive work in agriculture or afforestation is provided immediately.

Executives often request and are willing to accept psychological help in the matter of screening, either for vocational selection or for identifying cases in need of special treatment. Unfortunately their belief in the magic of mass psychological testing is in itself an indication that there is much work to be done in deepening their insight. Where the administrative framework is suitable, however, and where the use of the test results can be limited, the screening process not only is profitable in itself, but allows regular contact with the members of the administration and opportunities to work through with them the implications of the mental-hygiene point of view. A screening procedure for all immigrant children who come to Israel without families has recently been set up by the Lasker Mental Hygiene Center of Hadassah, and has already proved of considerable value in assisting the Jewish-agency administration with the selective disposal of the children to appropriate absorption centers.

Administrators have also sought advice from mental-health consultants in Israel on such problems as general immigrant morale, possibilities of modifying educational methods to suit the different ways of thinking of Oriental children, sex education among immigrants, public-relations policy in regard to rationing, and so on.

From experience so far, it would appear that the details of the problem referred for advice are not as important as the fact that the administrators feel the need for help and turn to mental-health workers for guidance. The latter attempt to achieve their educational goal during the coöperative working through of the problem, the main object being the communication of mental-hygiene attitudes, and the solution of the particular difficulty being of subsidiary importance.

The remainder of the present article will be devoted to a description of the major contribution of the Lasker Center in Israel to the field of mental-hygiene services for immigrants. This involves the program for the lowest level of staff workers, who deal directly with the immigrants on a day-to-day basis of personal contact and service.

In Israel, as elsewhere, these people are rarely trained professionals. In a richer country, which would be providing facilities for a relatively small immigration, most of the workers dealing with the immigrants' daily needs might be professionally trained and provided with appropriate techniques of interviewing and handling people. In Israel they are, by and large, amateurs, with no real training, and instead of professional techniques they use themselves and their own intuition and native personality gifts in their handling of the people with whom they deal. Because of the unique meaning of Israel to the Jewish people, and because of the general ideological framework of the country, there has been no lack of idealistic enthusiasts who volunteer and work with pioneering zeal in this nationally accepted task of bringing in the remnants of Jewry and helping them to integrate into the life of the country.

These workers are not protected by the professional distance ordinarily acquired by long and careful training and are, therefore, exposed to great emotional stress as the immigrants act out against them their own adaptation problems. Paranoid demands and accusations, aggressive reactions to

minor frustration, and tremendous dependency demands are constant problems that would tax the skill and strength of the most experienced professional. How much greater, then, is the strain on the amateur.

This is one of the most sensitive links in the mental-hygiene chain. The experience of the immigrant in his personal interrelationships during daily contacts with these workers, who to him are direct representatives of the general population of the new country, will determine in large measure with what speed he takes his first steps in acculturation, and how smoothly he can establish the new identifications.

The behavior and reactions of these workers, who are in direct contact with the immigrants, is a very potent factor that should be made as constructive as possible. It might be that an attempt should be made to train them and provide the techniques and the professional distance that they lack. But adequate training would take more time and resources than are available, and to give only a smattering of a training might make them worse by giving them poorly learned stereotyped techniques in place of the former confident use of their natural gifts. The danger of changing good amateurs into poor professionals must be constantly borne in mind.

A constructive method of dealing with the difficulties of the low-level worker has been worked out during the past three years by the Lasker Center as part of a mental-hygiene program for 17,000 immigrant homeless children. The latter are being cared for and educated by an organization called Youth Aliyah, which is a department of the Jewish Agency. The daily care of the children is left to instructors and house mothers, who are mainly untrained or who have had a minimum of basic training in handling children. Most of them are members of collective settlements, which are small agricultural communities organized on socialistic lines. These accept groups of immigrant children from Youth Aliyah as part of their contribution toward the upbuilding of the country. The children live in their own houses in the settlements and their day is divided between school studies and work training in the various aspects of the settlement's economy.

The instructors and house mothers are nominated by the settlements and are chosen primarily because of their suitable personalities, and also because they are loyal members of the

settlement and fully identified with its ideological and political program. The settlements are quite openly motivated by the goal of educating the immigrant children in such a way that when they grow up they will remain agricultural workers in their own or similar communities. The instructors and house mothers are their representatives in propagating their ideals to the children, and are chosen mainly with this end in view.

Whatever may be thought of this political approach to education, it certainly is effective. The educational results obtained by these amateurs, the majority of whom rarely remain in the work for more than two or three years, are amazingly good, and very much better than what one could expect from even fairly well-trained professionals.

They are supervised in the technical aspects of their work by a small team of professional educators. But it is their own unremitting toil and burning enthusiasm, and also the fact that they are supported by the surrounding group of their fellow members of the settlement, that account for the rapidity with which the children identify with them and accept their services.

Despite this success with the majority of children, however, it was found that many were failing dismally with certain types of problem. Most instructors rated about 15 per cent of the children under their care as "disturbed" and requested their removal to special psychotherapeutic institutions. Clinical investigation showed that in certain cases this demand was justified because the children were indeed suffering from intellectual backwardness or emotional disorder to an extent where specialized care was essential. A large proportion of the disturbed children, however, were fairly normal, and should really have been labeled "disturbing" children, since their reactive disorder of behavior was of importance mainly because it disturbed the instructors and house mothers. It was found, moreover, that the level of tolerance to different kinds of behavior disorder varied widely among different instructors. There was often a correlation between the personality make-up of the adult and the specific disturbance that he was unable to tolerate. His handling of these particular disturbed children was so inept in comparison with his general standard of care that it was difficult to avoid a comparison with the mother whose emotional relationship with one of her

children is specifically disturbed and results in that child's becoming a "problem child."

This and many other problems of the instructors and house mothers were handled by organizing for them a case-work counseling service. The Lasker Center case-workers traveled around regularly to the settlements, and offered their help to the instructors in the form of individual and group discussions on their difficulties with individual problem children. During these discussions, a supportive emotional relationship was built up between instructor and case-worker. The former was helped on the basis of this to see the case from the point of view of the reactions of the child to the frustration of his needs rather than as a stereotype, such as neurosis, sexual disorder, aggression, and so on, to which the instructor might be sensitive. As soon as he could perceive the difficulties of the child disentangled from his own problems, his approach often became human and constructive instead of a rather helpless rejection.

During this emotional interrelationship with the case-worker there was often some specific relief of tension in the instructor in regard to his own personality problems. In no case has the function of the case-worker been broadened to include therapy for the instructor, the details of whose personal life are kept strictly out of the discussion. The adult may have been disturbed by reacting to his own problems as perceived in the child, and he was often helped to overcome them indirectly, at least to a limited degree, when the case-worker assisted him to help the child to deal with his difficulties. He was thus helped to be free not only in relation to this child, but also in many other aspects of his work with the other children.

It has proved possible to provide emotional support to a large number of instructors and house mothers by means of such techniques of focused case-work. This has resulted in a marked change in the general emotional atmosphere in Youth Aliyah. There has been a rise in the threshold of tolerance to the symptoms of adaptation difficulties in the children, who are now handled as children with problems, rather than as "problem children," needing specialized psychological treatment.

By means of a counseling service of this kind, a relatively

small team of mental-health workers has been able to make a major contribution to the well-being of a large number of immigrants by directly focusing its efforts on what is believed to be a critical link in the mental-hygiene chain.

To summarize, in this paper the psychological problems of immigrants have been briefly discussed from the point of view of loss of external ego supports produced by broken identifications with the old environment, and the increased strains that the weakened ego is called upon to bear in adapting to the new country. An outline has been given of the usual adaptation process and some of the patterns of breakdown common during this process have been listed.

A description has been given of the efforts of mental-health workers in Israel in dealing with a vast wave of immigrants. Emphasis has been laid on directing these efforts in such ways as to produce the maximum of benefit to the community, and examples have been given of work at three levels:

1. Small psychiatric units have been established which have used a team approach to handle the problems of individual immigrants. The emphasis has been on social adaptation of the individual client, and also on using his case for research and the training of other professional workers.
2. Expert consultation services have been provided for administrators responsible for policy making and its implementation, so that wherever possible these can be enlightened by an understanding of the emotional needs of the immigrants.
3. A case-work counseling service has been provided for nonprofessional workers catering to the daily needs of immigrant children. The importance of the mental-hygiene rôle of this worker has been emphasized as well as his special difficulties. A few case-workers have been able to help a large number of these low-level workers overcome their emotional difficulties in dealing with the adaptation problems of their charges. This has resulted in an improvement in the general emotional atmosphere of a large organization dealing with immigrant children.

RATES OF DISCHARGE AND RATES OF MORTALITY AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS*

SECOND PAPER

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SYSTEMATIC studies are being conducted in the New York State Department of Mental Hygiene to determine rates of discharge and of mortality following admission to the state hospitals. A new statistical system was adopted by the department of mental hygiene as of April 1, 1943. This system required the preparation of a punched card for every patient on the books of the state and licensed mental hospitals on April 1, 1943, and for every patient admitted after that date. Punched cards were also prepared for the patients upon discharge or death. The punched cards for the same patient are brought together in a permanent file and thus make possible studies of the outcome of treatment.

In a previous study,[1] analyses were made of first admissions to the New York civil state hospitals during the fiscal year that began April 1, 1943, and ended March 31, 1944. When the study began, the histories of admissions, discharges, and deaths were available in the statistical files through March 31, 1949. From among the patients so admitted, those patients were selected for study who had not been transferred to or readmitted to another mental hospital outside of the New York State hospital system. The history of each patient in the group was then followed for a period of exactly five years from the date of admission.

The present study is based upon a second group of first admissions to the New York civil state hospitals during the

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[1] See "Rates of Discharge and Rates of Mortality Among First Admissions to the New York Civil State Hospitals," by Benjamin Malzberg. MENTAL HYGIENE, Vol. 36, pp. 104–20, January, 1952.

year that began April 1, 1944, and ended March 31, 1945. The same method of selection was employed. The follow-up period with respect to hospitalization ended March 31, 1949. In order to maintain consistency with respect to time, each patient was followed for a period of four years from the date of admission. The number included in this analysis is 12,091, of whom 5,554 were males, and 6,537, females.

A fundamental problem is how to measure the duration of treatment. In the first study, the duration was measured from the date of admission to the date of removal from the books. There are some who question this procedure, and who would measure the duration up to the date of placement in convalescent care (parole). The latter is undoubtedly appropriate from an administrative viewpoint, as it is related to the problems of the availability of beds and to expenditures for maintenance. The duration of hospital residence, as so determined, is also of importance to the patient and to his family, since it represents the time when he is more or less limited with respect to personal liberty.

However, the duration of residence must be used also as an approximation to the duration of the disease. In this case, the date of parole cannot be the terminal point. Parole is treatment in another form, on an outpatient basis. Not only is psychotherapy so administered, but medical treatment in the form of shock therapy is given to many patients on an ambulatory basis. Furthermore, in the case of the same illness, the patient may pass back and forth from the status of an inpatient to that of an outpatient. Therefore, if administered properly, the time on parole must be included in the total duration of treatment, which should be measured from date of admission to date of discharge (or death).

It is thus evident that the duration of hospital residence, exclusive of time on parole, is not the same as the duration of treatment. Placement on parole is a variable procedure, dependent upon the attitude of the hospital authorities. If used ultra-conservatively, a patient will have a longer hospital residence; if used liberally, the residence is short. For accurate comparison, therefore, it appears reasonable to include the entire period of treatment. Underlying this, however, is the requirement that parole should not be an automatic procedure, patients being discharged on dates determined

in advance, but that they should be discharged whenever their conditions indicate that this is desirable and proper.

Male first admissions included in this study totaled 5,554. Of this total, 2,180, or 39.3 per cent, were discharged within four years after admission. (See Table 1.) Close to a fourth of the discharges occurred during the first three months after admission. There was a rapid reduction during the remainder of the first year, the total discharges during this period reaching 744, or 34.1 per cent of all discharges. The bulk of the discharges occurred during the second year, this being the

TABLE 1. PATIENTS DISCHARGED FROM THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

	Males			*Females*		
Period of hospitalization	Number of discharges	Per cent	Rate per 1,000 exposures *	Number of discharges	Per cent	Rate per 1,000 exposures *
First three months..	509	23.3	407.6	439	15.3	291.6
Second three months	135	6.2	142.8	131	4.6	106.4
Third three months	43	2.0	50.4	59	2.0	51.6
Fourth three months	57	2.6	70.8	47	1.6	43.2
First year	744	34.1	158.5	676	23.5	118.2
Second year	1,131	51.9	384.9	1,795	62.5	442.2
Third year	212	9.7	135.6	308	10.7	153.0
Fourth year	93	4.3	77.5	94	3.3	60.9
Total discharges..	2,180	100.0		2,873	100.0	

* On an annual basis.

period when most placements in convalescent care (parole) were terminated. There were very few discharges after the second year.

The highest discharge rate occurred during the first three months after admission. During this period there were 407.6 discharges per 1,000 annual exposures. The discharge rate declined rapidly during the remainder of the first year. The average discharge rate for the first year was 158.5. The discharge rate rose to 384.9 during the second year, but declined to 77.5 per 1,000 exposures during the fourth year after admission.

Of the 6,537 female first admissions, 2,873, or 43.9 per cent, were discharged within four years after admission. (See Table 1.) There were relatively fewer female discharges than male during the first year, but relatively more in the succeed-

ing years, especially during the second year. Almost two-thirds of the discharges occurred during the second year.

The discharge rate among females was 291.6 per 1,000 exposures during the first three months after admission. The discharge rate decreased to 43.2 during the final quarter of the first year. The average discharge rate for the first year was 118.2, compared with 158.5 for the males. During the

TABLE 2. DISCHARGES AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FOUR YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO AGE AT ADMISSION

	Males			*Females*		
	Number of first admissions *	Discharged		Number of first admissions *	Discharged	
Age (years)		Number	Per cent		Number	Per cent
Under 15	118	82	69.5	52	33	63.5
15–19	264	198	75.0	246	184	74.8
20–24	276	206	74.6	385	286	74.3
25–29	269	197	73.2	446	306	68.6
30–34	324	218	67.3	540	386	71.5
35–39	325	214	65.8	513	344	67.1
40–44	388	235	60.6	456	277	60.7
45–49	369	195	52.8	431	262	60.8
50–54	391	162	41.4	453	250	55.2
55–59	411	165	40.1	412	187	45.4
60–64	474	125	26.4	395	114	28.9
65–69	472	86	18.2	482	96	19.9
70–74	508	50	9.8	571	68	11.9
75–79	430	19	4.4	464	44	9.5
80–84	318	21	6.6	411	18	4.4
85 or over ...	207	6	2.9	262	14	5.3
Unascertained	10	1	....	18	4	....
Total.....	5,554	2,180	39.3	6,537	2,873	43.9

* Number of first admissions during the year ended March 31, 1945.

second year, however, the discharge rate increased to 442.2 per 1,000 exposures among females, compared with 384.9 among males.

The discharges varied inversely with the age at first admission. (See Table 2.) Of the 264 male first admissions aged 15 to 19, 75 per cent were discharged within four years after admission. The discharge rate remained high, though at a decreasing rate, through ages 40 to 44, but declined rapidly thereafter. Of those aged 70 or over at admission, only 96, or 6.6 per cent, were discharged within four years.

Among the female first admissions, the percentage discharged was more than 70 at the younger age levels. It fell to approximately 60 among those in the middle years, and continued to decline to a minimum of 8.4 per cent among those aged 70 or over.

There was a similar decline in percentage discharged when this was correlated with the duration of the mental disorder

TABLE 3. DISCHARGES AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FOUR YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO THE DURATION OF THE MENTAL DISORDER BEFORE ADMISSION

Duration of mental disorder before admission	*Males*			*Females*		
	Number of first admissions *	Discharged		Number of first admissions *	Discharged	
		Number	Per cent		Number	Per cent
Less than 1 month	585	320	54.7	586	356	60.8
1–3 months	1,207	540	44.7	1,610	907	56.3
4–6 months	459	191	41.6	675	354	52.4
7–11 months	192	74	38.5	311	158	50.8
1 year	500	194	38.8	680	273	40.1
2 years	316	99	31.3	435	128	29.4
3 years	152	48	31.6	255	72	28.2
4 years	111	40	36.0	155	38	24.5
5 years	83	20	24.1	189	43	22.8
6–9 years	124	40	32.3	176	52	29.5
10 years or over..	105	45	42.9	228	59	25.9
Unascertained	1,720	569	....	1,237	433	....
Total	5,554	2,180	39.3	6,537	2,873	43.9

* Number of first admissions during the year ended March 31, 1945.

before admission to the hospital. (See Table 3.) The discharges were most frequent among those with a history of prior duration of less than a year. But even in this group, the percentage declined among males from 54.7 among those with a history of less than a month, to 38.5 per cent among those with a history of more than six months. The percentage continued to decline to a minimum of 24.1 among those with a prior duration of five years. There was an increase in the discharge rate among those with a longer duration prior to admission. This may be fortuitous, though a similar increase was found in the earlier study.[1]

[1] *Ibid.*, p. 109.

Female first admissions showed a similar trend. Of those with a previous history of less than a month, 60.8 per cent were discharged within four years. Of those with a history of seven to eleven months prior duration, 50.8 per cent were subsequently discharged within four years. The rate of discharge declined to 22.8 per cent among those with a duration of five years, but rose after that period.

It may be noted that of the female first admissions with a history of a prior duration of less than two years, a higher percentage were discharged than occurred among males. On the other hand, male first admissions with a longer history (*i.e.*, with a prior duration of two or more years) had a higher percentage of discharges than the females. The same variation was seen in the earlier study.[1]

Table 4 summarizes the condition of the patients at time of discharge. There were 12,091 first admissions, of whom 5,053 were discharged. Of the latter, 1,868 were recovered, representing 15.4 per cent of the total first admissions. The total number discharged with all degrees of improvement was 4,580, or 37.9 per cent of all first admissions.

There was some variation with respect to sex. Of the 5,554 male first admissions, 13.1 per cent were discharged as recovered, and 34.5 per cent as improved in some degree. The corresponding percentages for the 6,537 female first admissions were 17.4 and 40.7, respectively.

The preceding rates of recovery and of improvement may be compared with those obtained from a follow-up of first admissions to the New York civil state hospitals between 1909 and 1913.[2] This was a fifteen-year follow-up, but the data were abstracted so as to show the condition of the patients at the end of the fourth year. For this group the recovery rate was 15.6 per cent, and the total improvement rate was 28.4 per cent. The recovery rate was on a par with that of the present study, but the total improvement rate was lower. However, first admissions with psychoses with cerebral arteriosclerosis, a group with a low recovery rate, represented only about 4 per cent of total first admissions during the early

[1] *Ibid.*, p. 109.

[2] See "Hospital Departures and Readmissions Among Mental Patients During the Fifteen Years Following First Admission," by Raymond G. Fuller. *Psychiatric Quarterly*, Vol. 4, October, 1930. p. 659.

TABLE 4. DISCHARGES AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS WITHIN FOUR YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	*Males*			*Females*			*Total*		
	Number	Per cent of total discharged	Per cent of first admissions	Number	Per cent of total discharged	Per cent of first admissions	Number	Per cent of total discharged	Per cent of first admissions
Recovered	730	33.4	13.1	1,138	39.6	17.4	1,868	37.0	15.4
Much improved.....	695	31.9	12.5	967	33.7	14.8	1,662	32.9	13.7
Improved	492	22.6	8.9	558	19.4	8.5	1,050	20.8	8.7
Unimproved	178	8.2	3.2	167	5.8	2.6	345	6.8	2.9
Without psychosis ...	85	3.9	1.5	43	1.5	0.7	128	2.5	1.1
Total discharges ...	2,180	100.0	39.3	2,873	100.0	43.9	5,053	100.0	41.8
Total first admissions *	5,554	.....	....	6,537	.....	....	12,091	.....	....

* Number of first admissions during the year ended March 31, 1945.

period, compared with over 20 per cent in 1945. This large increase weights the rate of improvement downward for the entire group. Therefore, separate comparisons will be made in later sections with respect to similar groups of mental disorders.

Mortality

Of the 5,554 male first admissions, 2,323, or 41.8 per cent, died within four years after admission. (See Table 5.) The heaviest mortality was during the first year after admission,

Table 5. Patients Dying in the New York Civil State Hospitals, Classified According to Period of Hospitalization After First Admission

Period of hospitalization	*Males*			*Females*		
	Number of deaths	Per cent	Rate per 1,000 exposures *	Number of deaths	Per cent	Rate per 1,000 exposures *
First three months..	1,119	48.1	844.8	1,038	45.4	657.2
Second three months	295	12.7	306.0	271	11.8	217.2
Third three months	167	7.2	192.4	181	7.9	156.4
Fourth three months	141	6.1	173.2	149	6.5	135.6
First year	1,722	74.1	332.3	1,639	71.6	264.4
Second year	299	12.9	118.5	326	14.3	98.1
Third year	190	8.2	122.4	177	7.7	90.9
Fourth year	112	4.8	92.6	146	6.4	93.1
Total deaths	2,323	100.0		2,288	100.0	

* On an annual basis.

when 1,722 died, or 31.0 per cent of the total male first admissions. Within this period, the severest mortality was within the first three months, when 1,119 patients died, representing 20.1 per cent of the first admissions, and almost half of the total deaths. The death rate per 1,000 annual exposures declined from 844.8 during the first three months, to 173.2 during the last quarter of the first year after admission. The average rate for the first year was 332.3. The death rate decreased rapidly after the first year, and fell to 92.6 during the fourth year.

Of the 6,537 female first admissions, 2,288, or 35.0 per cent, died during the four years following admission. (See Table 5.) There were 1,639 deaths during the first year, representing 71.6 per cent of all the deaths and 25.1 per cent of the first

admissions. The heaviest mortality occurred during the first three months, when 1,038 patients died, representing 45.4 per cent of all deaths, and 15.9 per cent of the first admissions. The death rate per 1,000 annual exposures was 657.2 during the first three months after admission. The rate declined to 135.6 during the last quarter of the first year, with an average of 264.4 for the first year. During the second year, the death

TABLE 6. DEATHS AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FOUR YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO AGE AT ADMISSION

	Males			*Females*		
	Number	Deaths		Number	Deaths	
Age (years)	of first admissions *	Number	Per cent	of first admissions *	Number	Per cent
Under 15	118	2	1.7	52	1	1.9
15–19	264	7	2.7	246	5	2.0
20–24	276	10	3.6	385	16	4.2
25–29	269	14	5.2	446	17	3.8
30–34	324	18	5.6	540	41	7.6
35–39	325	41	12.6	513	36	7.0
40–44	388	56	14.4	456	45	9.9
45–49	369	93	25.2	431	69	16.0
50–54	391	130	33.2	453	102	22.5
55–59	411	157	38.2	412	119	28.9
60–64	474	256	54.0	395	183	46.3
65–69	472	307	65.0	482	289	60.0
70–74	508	386	76.0	571	401	70.2
75–79	430	369	85.8	464	369	79.5
80–84	318	278	87.4	411	357	86.9
85 or over ...	207	194	93.7	262	228	87.0
Unascertained	10	5	....	18	10	....
Total	5,554	2,323	41.8	6,537	2,288	35.0

* Number of first admissions during the year ended March 31, 1945.

rate dropped to 98.1, and fell still further during the succeeding years.

It should be noted that males had a greater mortality than females, except for a slight and undoubtedly fortuitous exception during the fourth year after admission.

The deaths are correlated with age at admission in Table 6. It will be observed that they vary directly with age. Of the males admitted when aged less than 20 years, 2.4 per cent died within four years after admission. The percentage rose to 5.6 among those aged 30 to 34 at admission, and increased

steadily thereafter to a maximum in old age. Of those aged 80 or over, 89.9 per cent died within four years.

There was a similar correlation among females, though the percentages were less than those of the males of corresponding age. The percentage dying within four years after admission rose from 2.0 among those aged less than 20 years at admission to a maximum of 86.9 per cent among those aged 80 or over.

TABLE 7. DEATHS AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FOUR YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO THE DURATION OF THE MENTAL DISORDER BEFORE ADMISSION

Duration of mental disorder before admission	*Males*			*Females*		
	Number of first admissions *	Deaths		Number of first admissions *	Deaths	
		Number	Per cent		Number	Per cent
Less than 1 month	585	201	34.4	586	141	24.1
1–3 months	1,207	465	38.5	1,610	426	26.5
4–6 months	459	188	41.0	675	190	28.1
7–11 months	192	72	37.5	311	97	31.2
1 year	500	227	45.4	680	255	37.5
2 years	316	165	52.2	435	207	47.6
3 years	152	70	46.1	255	122	47.8
4 years	111	52	46.8	155	76	49.0
5 years	83	48	57.8	189	93	49.2
6–9 years	124	51	41.1	176	76	43.2
10 years or over ..	105	29	27.6	228	75	32.9
Unascertained	1,720	755	....	1,237	530	....
Total	5,554	2,323	41.8	6,537	2,288	35.0

* Number of first admissions during the year ended March 31, 1945.

The proportion of deaths also rose with the increase of the duration of the mental disease before hospitalization. (See Table 7.) Of the male first admissions with a prior history of less than a year, 39.5 per cent died within four years after admission. Of those with a history of a year, 45.4 per cent died. Of those with a history of two years, 52.2 per cent died. There were some fluctuations in the mortality among those with a longer history of mental disease, but in general the percentages dying within four years after admission to the hospitals exceeded those among the patients with a short history.

The rising trend in correlation with the prior duration of

the mental disease is clear among the female first admissions. Of those with a history of less than a year, 26.8 per cent died within four years after admission. This rose to 37.5 per cent among those with a previous history of a year's duration, to 47.6 per cent among those with a history of two years' duration, to a maximum of 49.2 among those with a history of four years' duration. As with the males, the percentage dying decreased among those with prior histories of six or more years, but they were higher, nevertheless, than the percentages for those with the shortest durations.

Table 8 shows the number of first admissions remaining on the books of the New York civil state hospitals at the end of

TABLE 8. NUMBER OF PATIENTS REMAINING ON THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS AT THE END OF SPECIFIC PERIODS AFTER FIRST ADMISSION

	Males		*Females*	
End of period	Number	Per cent of total first admissions	Number	Per cent of total first admissions
Third month	3,987	71.8	5,139	78.6
Sixth month	3,596	64.7	4,770	73.0
Ninth month	3,405	61.3	4,566	69.8
First year	3,235	58.2	4,421	67.6
Second year	1,806	32.5	2,309	35.3
Third year	1,446	26.0	1,891	28.9
Fourth year	1,252	22.5	1,672	25.6

specific periods after admission. Those remaining include patients who were discharged after first admission, but were subsequently readmitted. The results were in close agreement with previous tabulations.[1] Of the 5,554 male first admissions, 3,987, or 71.8 per cent, were still on the books three months after admission. By the end of the first year, this had been reduced to 3,235, or 58.2 per cent of the total. By the end of the second year, only 1,806, or 32.5 per cent, were still on the books. The totals decreased slowly after the second year, because of the decrease both of discharge and of death rates after the second year of residence. At the end of the follow-up period of four years, there were still 1,252 male first admissions on the books, or 22.5 per cent of the total.

Largely because of their lower death rates, there were relatively more females on the books at the close of specified

[1] See Malzberg, *op. cit.*, p. 113.

periods than males. Of the 6,537 female first admissions, 4,421, or 67.6 per cent, were still on the books at the close of the first year after admission, compared with 58.2 per cent of the males. At the end of the second year after admission, there were 2,309 females still on the books, or 35.3 per cent of the original total. At the end of the fourth year after admission, there were 1,672 females on the books, or 25.6 per cent, compared with 22.5 per cent of the males.

The rates of discharge and of mortality shown in the preceding sections are an average for all first admissions. It is necessary to show how these rates vary with different types

TABLE 9. PATIENTS WITH DEMENTIA PRAECOX DISCHARGED FROM THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	*Males*			*Females*		
	Number of discharges	Per cent	Rate per 1,000 exposures *	Number of discharges	Per cent	Rate per 1,000 exposures *
First three months ..	88	12.2	310.4	100	9.0	222.0
Second three months	47	6.5	181.2	50	4.5	118.8
Third three months..	17	2.4	68.8	23	2.1	56.4
Fourth three months	22	3.0	90.8	15	1.4	37.6
First year	174	24.1	153.9	188	17.0	104.9
Second year	413	57.2	439.1	736	66.2	466.1
Third year	96	13.3	185.1	150	13.5	180.2
Fourth year	39	5.4	94.0	37	3.3	55.5
Total discharges..	722	100.0	.....	1,111	100.0	.....

* On an annual basis.

of diagnosis. For this purpose, we shall consider separately the outcome of hospitalization for groups of first admissions with dementia praecox and with psychoses with cerebral arteriosclerosis, who were admitted to the New York civil state hospitals during the fiscal year ended March 31, 1945.

Of the 1,142 male first admissions with dementia praecox, 722, or 63.2 per cent, were discharged within four years after admission. (See Table 9.) In contrast, only 39.3 per cent of the total first admissions were discharged within four years after admission. The greatest number of discharges occurred during the second year after admission, this interval including 413 discharges, or 57.2 per cent of all discharges. The rate of

discharges per 1,000 annual exposures was 310.4 during the three months after first admission. The discharge rate decreased rapidly during the remainder of the first year. The average for the year was 153.9. The rate increased to 439.1 during the second year, and then decreased to 94.0 during the fourth year after admission.

There were 1,818 female first admissions with dementia praecox, of whom 1,111, or 61.1 per cent, were discharged within four years. This was greatly in excess of the corresponding percentage of discharges, 43.9, among all female first admissions. Two-thirds of the discharges occurred during the second year after admission. There were 100 discharges during the first three months, corresponding to an annual rate of 222.0 per 1,000 exposures. The rate decreased to 37.6 during the last quarter. The average rate for the first year was 104.9. The maximum rate of discharge occurred during the second year, when the discharges totaled 736, corresponding to a rate of 466.1. The rate fell to 55.5 during the fourth year.

Of the 2,960 first admissions with dementia praecox, 521, or 17.6 per cent, were discharged as recovered. (See Table 10.) A total of 1,686, or 57.0 per cent, were discharged with some degree of improvement. The recovery rates were 14.3 and 19.7 per cent for males and females, respectively. The total rates of improvement were 56.9 and 57.0 per cent, for males and females, respectively.

These results may be compared with corresponding data for first admissions between 1909 and 1913.[1] For the latter group, the recovery rate after four years was 2.0 per cent. The total rate of improvement was 16.9 per cent. It is immediately evident that there has been a remarkable improvement in recent years in the treatment of dementia praecox, a result which must be attributed primarily to the introduction of the newer methods of treatment.

The death rates among the first admissions with dementia praecox were low. (See Table 11.) There were only 47 deaths among the males during the four years following admission, or 4.1 per cent of the total admissions, compared with 41.8 per cent among all male first admissions. The heaviest mortality occurred during the first year after admission. There

[1] See Fuller, *op. cit.*, p. 654.

TABLE 10. DISCHARGES AMONG FIRST ADMISSIONS WITH DEMENTIA PRAECOX TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FOUR YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	*Males*			*Females*			*Total*		
	Number	Per cent of total discharged	Per cent of first admissions	Number	Per cent of total discharged	Per cent of first admissions	Number	Per cent of total discharged	Per cent of first admissions
Recovered	163	22.6	14.3	358	32.2	19.7	521	28.4	17.6
Much improved.....	271	37.5	23.7	437	39.3	24.0	708	38.6	23.9
Improved	216	29.9	18.9	241	21.7	13.3	457	24.9	15.4
Unimproved	72	10.0	6.3	75	6.8	4.1	147	8.0	5.0
Total discharges ...	722	100.0	63.2	1,111	100.0	61.1	1,833	100.0	61.9
Total first admissions	1,142	.....	....	1,818	.....	....	2,960	.....	....

were 23 deaths during this period, almost half of the total. There were 15 deaths during the first three months, corresponding to an annual death rate of 54.8 per 1,000 exposures, compared with a rate of 844.8 among all first admissions. The average annual death rate during the first year after admission was 21.8 among male first admissions with dementia praecox, but it was 332.3 for all male first admissions. The death rate decreased after the first year of hospitalization

TABLE 11. PATIENTS WITH DEMENTIA PRAECOX DYING IN THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

	Males			*Females*		
Period of hospitalization	Number of deaths	Per cent	Rate per 1,000 exposures *	Number of deaths	Per cent	Rate per 1,000 exposures *
First three months..	15	31.9	54.8	31	35.7	70.0
Second three months	5	10.7	19.6	5	5.7	12.0
Third three months	1	2.1	4.0	5	5.7	12.4
Fourth three months	2	4.3	8.4	5	5.7	12.4
First year	23	49.0	21.8	46	52.8	26.7
Second year	9	19.1	12.2	10	11.5	8.2
Third year	9	19.1	18.9	11	12.7	14.4
Fourth year	6	12.8	15.1	20	23.0	30.4
Total deaths	47	100.0	....	87	100.0	....

* On an annual basis.

and continued at a much lower level among patients with dementia praecox than among all first admissions.

Of the 1,818 female first admissions with dementia praecox, 87, or 4.8 per cent, died during the four years after admission, compared with 35.0 per cent of all female first admissions. More than half of the deaths occurred during the first year after admission, and of these the majority occurred during the first three months. The death rate during this period, on an annual basis, was 70.0 per 1,000 exposures, compared with 657.2 among all female first admissions. The death rate dropped rapidly during the remainder of the first year, and averaged 26.7 for the year, compared with 264.4 for all first admissions. The death rates dropped markedly during the second year of hospitalization, but rose, probably fortuitously,

during the remaining two years. The rates were far below those for all first admissions, however.

Because of the low mortality rates, the relative number of patients remaining on the books remained high. (See Table 12.) Of all the male first admissions with dementia praecox, 88.8 per cent were on the books after one year. Half (52.5 per cent) were on the books at the end of the second year, and 42.5 per cent were still on the books at the end of the fourth year. The corresponding percentages for all male first admissions were 58.2, 32.5, and 22.5.

TABLE 12. NUMBER OF PATIENTS WITH DEMENTIA PRAECOX REMAINING ON THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS AT THE END OF SPECIFIC PERIODS AFTER FIRST ADMISSION

	Males		*Females*	
End of period	Number	Per cent of total first admissions	Number	Per cent of total first admissions
Third month	1,076	94.2	1,732	95.3
Sixth month	1,039	91.0	1,699	93.5
Ninth month	1,026	89.8	1,695	93.2
First year	1,014	88.8	1,703	93.7
Second year	600	52.5	966	53.1
Third year	523	45.8	845	46.5
Fourth year	485	42.5	798	43.9

Of the female first admissions with dementia praecox, 93.7 per cent were on the books at the end of the first year, compared with only 67.6 per cent of all first admissions. Half of those with dementia praecox were on the books at the end of the second year, compared with a third of all first admissions. At the end of the fourth year, 43.9 per cent of those with dementia praecox were still on the books, compared with only 25.6 per cent of all first admissions.

The experience of first admissions with psychoses with cerebral arteriosclerosis differed significantly from that of dementia praecox. There were 1,410 male first admissions with psychoses with cerebral arteriosclerosis, of whom only 204, or 14.4 per cent, were discharged within four years after admission, compared with 39.3 per cent of total first admissions, and 63.2 per cent of those with dementia praecox. (See Table 13.) There were 53 discharges during the first three months, corresponding to a rate of 181.6 per 1,000 annual

exposures. The average discharge rate during the first year was 65.8. The rate rose to 210.5 during the second year, and decreased to 40.3 during the fourth year.

Of the 1,392 female first admissions, 230, or 16.5 per cent, were discharged within four years after admission. The corresponding percentage for all female first admissions was 43.9. It was 61.1 per cent for female first admissions with dementia praecox. The discharge rate varied from 118.0

TABLE 13. PATIENTS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS DISCHARGED FROM THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	*Males*			*Females*		
	Number of discharges	Per cent	Rate per 1,000 exposures *	Number of discharges	Per cent	Rate per 1,000 exposures *
First three months..	53	26.0	181.6	34	14.8	118.0
Second three months	9	4.4	44.8	6	2.6	29.2
Third three months	2	1.0	11.6	6	2.6	33.2
Fourth three months	4	2.0	25.6	6	2.6	36.4
First year	68	33.4	65.8	52	22.6	50.4
Second year	110	53.9	210.5	149	64.8	266.8
Third year	17	8.3	55.6	22	9.6	70.1
Fourth year	9	4.4	40.3	7	3.0	30.3
Total discharges..	204	100.0	.....	230	100.0	.....

* On an annual basis.

per 1,000 annual exposures during the first three months to 36.4 during the last quarter of the first year, with an average of 50.4 for the first year. The rate rose to 266.8 during the second year, then fell to a minimum of 30.3 during the fourth year.

Of the 2,802 first admissions with psychoses with cerebral arteriosclerosis, 88, or 3.1 per cent, were discharged as recovered, and only 395, or 14.1 per cent, were discharged with some degree of improvement. (See Table 14.) There was little sex variation in this respect.

Compared with the experience of four decades ago,[1] there has been little improvement in this respect. The earlier

[1] See Fuller, *op. cit.*, p. 656.

TABLE 14. DISCHARGES AMONG FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FOUR YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

Condition at discharge	*Males*			*Females*			*Total*		
	Number	Per cent of total discharged	Per cent of first admissions	Number	Per cent of total discharged	Per cent of first admissions	Number	Per cent of total discharged	Per cent of first admissions
Recovered	45	22.1	3.2	43	18.7	3.1	88	20.3	3.1
Much improved.....	79	38.7	5.6	88	38.3	6.3	167	38.4	6.0
Improved	63	30.9	4.4	77	33.4	5.5	140	32.3	5.0
Unimproved	17	8.3	1.2	22	9.6	1.6	39	9.0	1.4
Total discharges ...	204	100.0	14.4	230	100.0	16.5	434	100.0	15.4
Total first admissions	1,410	.....	....	1,392	.....	....	2,802	.....	....

recovery rate was 2.4 per cent, compared with 3.1 per cent. The total rates of improvement were 11.9 and 14.1, respectively.

In contrast to the low rates of discharge, we find high death rates, a consequence of the physical impairments caused by this disease. (See Table 15.) There were 1,017 deaths among the male first admissions during the four years following admission, or 72.1 per cent of the total. Among all male first admissions, only 41.8 per cent died during the same period.

TABLE 15. PATIENTS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS DYING IN THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

	Males			*Females*		
Period of hospitalization	Number of deaths	Per cent	Rate per 1,000 exposures *	Number of deaths	Per cent	Rate per 1,000 exposures *
First three months ..	487	47.9	(1,000.0)	480	49.7	(1,000.0)
Second three months	127	12.4	586.8	111	11.5	507.6
Third three months	75	7.4	409.2	70	7.3	369.2
Fourth three months	64	6.3	390.8	58	6.0	340.0
First year	753	74.0	547.2	719	74.5	726.4
Second year	133	13.1	249.1	125	12.9	228.7
Third year	80	7.9	237.0	66	6.8	196.4
Fourth year	51	5.0	208.6	56	5.8	219.2
Total deaths	1,017	100.0	.....	966	100.0	.....

* On an annual basis.

The corresponding percentage for dementia praecox was 4.1. There were 487 deaths during the first three months. Had this rate continued, all of the 1,410 male first admissions would have died in a little over six months, but the rate dropped during the remainder of the year, and finished with an average of 547.2 for the year. The death rate fell during the following years, but remained high nevertheless, the rate being 208.6 during the fourth year. The corresponding rate for all male first admissions was 92.6. For male first admissions with dementia praecox, the corresponding rate was 15.1.

Of the 1,392 female first admissions with psychoses with cerebral arteriosclerosis, 966, or 69.4 per cent, died during the four years following admission, compared with 35.0 per cent among all female first admissions, and 4.8 per cent among female first admissions with dementia praecox. As with the

males, the death rate was extremely great during the first three months after admission. Half of the total deaths occurred during this period. Had this rate continued, all the patients would have died within six months. However, the average death rate for the first year after admission was 726.4. The rate dropped to 196.4 during the third year, and to 219.2 during the fourth year. The latter were greatly in excess of the corresponding rates for all female first admissions and for those with dementia praecox.

Because of the heavy mortality, the number of patients with

TABLE 16. NUMBER OF PATIENTS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS REMAINING ON THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS AT THE END OF SPECIFIC PERIODS AFTER FIRST ADMISSION

	Males		*Females*	
End of period	Number	Per cent of total first admissions	Number	Per cent of total first admissions
Third month	874	62.0	888	63.8
Sixth month	745	52.8	773	55.5
Ninth month	674	47.8	697	50.1
First year	608	43.1	640	46.0
Second year	357	25.3	361	25.9
Third year	263	18.7	276	19.8
Fourth year	205	14.5	217	15.6

psychoses with cerebral arteriosclerosis remaining on the books at specified periods after first admission dropped rapidly. (See Table 16.) Of the males, only 43.1 per cent were on the books at the end of the first year of hospitalization, compared with 58.2 per cent of all male first admissions and 88.8 per cent of those with dementia praecox. The percentage dropped rapidly to 14.5 at the end of the fourth year, compared with 22.5 per cent for all first admissions and 42.5 per cent for dementia praecox.

Of the 1,392 female first admissions with cerebral arteriosclerosis, only 640, or 46.0 per cent, were on the books at the end of the first year, compared with 67.6 per cent of all first admissions, and 93.7 per cent for dementia praecox. The percentages at the end of the fourth year were 15.6 for psychoses with cerebral arteriosclerosis, 25.6 for all first admissions, and 43.9 for those with dementia praecox.

SUMMARY

This study reports the results of a follow-up of the hospital histories of first admissions to the New York civil state hospitals during the fiscal year that ended March 31, 1945. Each patient in this group was followed for a period of four years from the date of admission.

Of the 5,554 male first admissions included in this study, 39.3 per cent were discharged within four years after admission, and 34.5 per cent showed some degree of improvement. This exceeded the rate of improvement reported for an earlier period. Of the 6,537 female first admissions, 2,873, or 43.9 per cent, were discharged within the period of four years, and 40.7 per cent showed some degree of improvement. This also exceeded the rate of improvement of the earlier period.

However, rates of discharge and of improvement depend upon the type of mental diagnosis. Of 1,142 male first admissions with dementia praecox, 722, or 63.2 per cent, were discharged within four years, and 56.9 per cent showed some degree of improvement, including 14.3 per cent who were recovered. Of 1,818 female first admissions with dementia praecox, 1,111, or 61.1 per cent, were discharged within four years. Those showing some degree of improvement represented 57.0 per cent of the total first admissions. Those reported as recovered represented 19.7 per cent. The rates of recovery and of general improvement were both substantially higher than the corresponding rates of the earlier period, and testify to the value of the shock therapies.

First admissions with psychoses with cerebral arteriosclerosis differ significantly in outcome from those with dementia praecox. Of the 1,410 male first admissions, only 14.4 per cent were discharged within four years, compared with 63.2 per cent of the group with dementia praecox. Among females the corresponding percentages were 16.5 and 61.1, respectively. The rates of improvement were equally low among first admissions with psychoses with cerebral arteriosclerosis. In addition, there has been little improvement in such rates during the past 40 years.

Rates of mortality are low among patients with dementia praecox, lower than for all first admissions as a group, but the death rates for admissions with cerebral arteriosclerosis are far above the average.

BOWLBY'S "MATERNAL CARE AND MENTAL HEALTH"*

NINA RIDENOUR, PH.D.

The National Association for Mental Health

ONLY once in a long, long while does a scientific contribution appear which is as perfect of its kind as this remarkable monograph of Bowlby's. Here one finds a beautifully balanced combination of the practical and the theoretical, the general and the specific, the comprehensive and the selective. Reports of the work of others (often dull reading) here come alive under the pen of one who is himself philosopher, practician, scientist, and creative thinker. Problems major and minor are analyzed, organized, related to each other and to the whole. The reader emerges with a clear picture of the scientific status of each problem: the parts of it where the evidence is and is not clear, what kind of further investigation is needed, and the practical implications for child care of what is known so far. This is a solid practicum for present workers in the field, and a stimulating guide for future investigators.

Here are a few examples of the kinds of practical problem concerning which Bowlby evaluates the scientific evidence:

At what age does maternal deprivation have its most serious consequences?

At what age does the child begin to be less vulnerable to loss of maternal care?

What is the length of the safety margin during which deprivation can, if absolutely necessary, be permitted, and within which there is time to make good damage already done?

What is the optimum age for adoption?

What are the "favorable conjunctions" to be sought in placing children in boarding homes?

* *Maternal Care and Mental Health. A Report Prepared on Behalf of the World Health Organization as a Contribution to the United Nations Program for the Welfare of Homeless Children.* By John Bowlby, M.D. (World Health Organization Monograph Series No. 2. Second edition.) New York: Columbia University Press, 1952. 194 p.

The table of contents indicates the scope of the monograph. Some of the subjects covered are: origins of mental ill health; review of evidence of effects of deprivation; causes and prevention of family failure; illegitimacy and deprivation; adoption and boarding homes; group care; care of maladjusted and sick children; administration of child-care services; problems for research.

The basic and recurrent theme is the presentation of the evidence that "the quality of the parental care which a child receives in his earliest years is of vital importance for his future mental health." Bowlby states what might almost be called his credo somewhat as follows:

> "... what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment. Given this relationship, the emotions of anxiety and guilt, which in excess characterize mental ill-health, will develop in a moderate and organized way. When this happens, the child's characteristic and contradictory demands, on the one hand for unlimited love from his parents and on the other for revenge upon them when he feels that they do not love him enough, will likewise remain of moderate strength and become amenable to the control of his gradually developing personality."

Bowlby points out that the concept of the broken home is "scientifically unsatisfactory and should be abandoned." In place of this concept he recommends putting the concept of the disturbed parent-child relationship which is frequently, but not necessarily, associated with it.

In the section, *Review of Evidence on Effects of Deprivation,* he analyzes three types of study:

> "(a) Studies, by direct observation, of the mental health and development of children in institutions, hospitals, and foster-homes—direct studies.
>
> "(b) Studies which investigate the early histories of adolescents or adults who have developed psychological illnesses—retrospective studies.
>
> "(c) Studies which follow up groups of children who have suffered deprivation in their early years with a view to determining their state of mental health—follow-up studies."

Bowlby stresses the amount of agreement found among investigators. He says:

> "The extent to which these studies, undertaken by people of many nations, varied training and, as often as not, ignorant of each others'

> conclusions, confirm and support each other is impressive. What each individual piece of work lacks in thoroughness, scientific reliability, or precision is largely made good by the concordance of the whole. Nothing in scientific method carries more weight than this."

Among the direct studies of the ill effects on young children of complete deprivation of maternal care, any number of investigators describe the typical separated infant as "listless, quiet, unhappy, and unresponsive to a smile or coos." Bowlby points out the similarity of this type of reaction in infants and the symptoms of the typical adult depressive patient in a mental hospital.

> "The emotional tone is one of apprehension and sadness, there is a withdrawal from the environment amounting to rejection of it, there is no attempt to contact a stranger and no brightening if this stranger contacts him. Activities are retarded and the child often sits or lies inert in a dazed stupor. Insomnia is common and lack of appetite universal. Weight is lost and the child becomes prone to intercurrent infections. The drop in D.Q. [development quotient] is precipitous."

These adverse results can be partially avoided during the first year of life if the child is mothered by a substitute. Vulnerability to lack of maternal care is found to diminish slowly. It is still serious through the ages of three and five although less so than earlier.

Some of the typical features of delinquent children who have had grossly disturbed early relationships with their mothers are listed as follows:

> "superficial relationships;
> no real feeling—no capacity to care for people or to make true friends;
> an inaccessibility, exasperating to those trying to help;
> no emotional response to situations where it is normal—a curious lack of concern;
> deceit and evasion, often pointless;
> stealing;
> lack of concentration at school."

Evidence is cited to support the hypothesis that there is a specific relation between prolonged deprivation in the early years and the development of an affectionless psychopathic character given to persistent delinquent conduct and extremely difficult to treat.

Among the follow-up studies described, those of Goldfarb are analyzed in considerable detail and his summary of his findings are quoted:

> "Briefly, the institution children present a history of aggressive, distractible, uncontrolled behavior. Normal patterns of anxiety and self-inhibition are not developed. Human identifications are limited, and relationships are weak and easily broken. . . .
>
> "Finally, the fact that the personality distortions caused by early deprivation are not overcome by later community and family experience must be stressed. There is a continuity of essential traits as late as adolescence. If anything, there is a growing inaccessibility to change."

The similarity is pointed out between observations on war orphans and refugees and those of other deprived children. Among his "Interim Conclusions," Bowlby states: "Certainly it would appear that the more complete the deprivation in the early years, the more isolated and asocial the child, whereas the more that deprivation is interspersed with satisfaction, the more ambivalent and antisocial he becomes." He presents some interesting differences of opinion about the age at which deprivation has the most evil consequences. He himself had noted that the separations which appeared pathogenic had all occurred after the age of six months and in a majority after the age of twelve months. From these he was inclined to conclude that separations and deprivations in the first six months of life were less important for the child's welfare than later ones. This has, however, been called into question by Spitz and Wolf and indirectly by Klein. Bowlby summarizes current opinion as follows:

> "For the present, therefore, it may be recorded that deprivation occurring in the second half of the first year of life is agreed by all students of the subject to be of great significance and that many believe this to be true also of deprivation occurring in the first half, especially from three to six months."

The time limit within which the provision of mothering can make good some of the damage done by earlier deprivations is probably within the first year and a half. Goldfarb's work demonstrates that for severely deprived children, the mothering is almost useless if delayed after the age of two-and-one-half years. Bowlby also stresses Goldfarb's conclusions concerning the failure in treatment of all those who have suffered rejection or who have never had a libidinal tie. He quotes Goldfarb's remark that he has never seen "even one example of significantly favorable response to treatment by traditional methods of child psychiatry." Bowlby also quotes Bender at this point as saying that "once the defect is created it cannot be corrected." She recommends that methods of

care should make no attempt to be therapeutic or corrective, but "should be protective and should aim to foster a dependent relationship." Other observers are quoted as being more hopeful.

The chapter, *Causes of Family Failure in Western Communities with Special Reference to Psychiatric Factors,* is well summarized in the following paragraph:

> "From the foregoing, it is evident that in a society where death-rates are low, the rate of employment high, and social welfare schemes adequate, it is emotional instability and the inability of parents to make effective family relationships which are the outstanding cause of children becoming deprived of a normal home life. This itself is an important conclusion, but it is perhaps even more important to note that the origin of adults' being unable to make effective family relationships is not infrequently itself the result of their having been deprived of a normal home life in their own childhood. Thus the investigator is confronted with a self-perpetuating social circle in which children who are deprived of a normal home life grow up into parents unable to provide a normal home life for their children, thus leading to another generation of adults unable to do the same for theirs. Most workers in child care regard this vicious circle as playing an important part in the total problem. It is a matter which clearly requires much further investigation."

The section, *Prevention of Family Failure,* stresses the fact that the long-term program of mental hygiene is "the psychiatric care of individual families writ large. . . . That part of it primarily concerned with social and psychological services, such as marriage guidance, child guidance, and work with the parents of very young children, requires large numbers of skilled workers."

Bowlby makes a strong point of the necessity of professional personnel with psychiatric training—physicians, nurses, social workers, and others. Only if all these workers are trained can the work be done on the necessary scale, he says, and in order to bring about this extensive training and retraining, there must be some radical changes in attitudes.

> "The principles and practice of psychological medicine and preventive mental health cannot be learnt in a few weeks or even a few months any more easily than can the principles and practice of physical medicine and preventive physical health be learnt in this time. Unless the amount of training and change of attitude which are required are clearly recognized and tackled, the devolution of this work to the non-specialist will prove abortive. All those aspiring to work in this field must become thoroughly familiar with the psychology and psychopathology of human relations, alive to unconscious motivation, and able to modify it. Such widespread professional training and retraining is to-day the foremost need both in mental hygiene and the preservation of the family."

In the chapter, *Illegitimacy and Deprivation,* some interesting points are made and some little-known studies are quoted. Bowlby points out "that the girl who has a socially unacceptable illegitimate baby often comes from an unsatisfactory family background and has developed a neurotic character, the illegitimate baby being in the nature of a symptom of her neurosis."

The character of the unmarried father is rarely studied and not much is known of him. Wittkower has studied factors that make for promiscuity. Among these he lists the need for affection, situations that arouse anxiety, and situations that arouse resentment. He says, "The so-called biological sex-urge, strange though it may appear, plays a minor part in most cases of promiscuity," in the same way that thirst has little to do with chronic alcoholism. Other studies also support the major point here, which is that it is emotionally disturbed men and women who produce illegitimate children of a socially unacceptable kind.

In the chapter on adoption, Bowlby quotes a British study: "The central paradox of work for deprived children is that there are thousands of childless homes crying out for children and hundreds of Homes filled with children in need of family life." All the evidence in the first half of the monograph points unmistakably to its being in the interests of the adopted baby's mental health for him to be adopted soon after birth. Early adoption is also in the interests of the adoptive parents. The usual arguments against early adoption are that it requires what might be a precipitate decision by the mother, that the baby cannot be breast fed, and that there is less opportunity to assess the baby's potential development. After examining the evidence, Bowlby concludes that "the arguments against early adoption are far less strong than they appear at first sight. On psychiatric and social grounds adoption in the first two months should become the rule, though some flexibility will always be necessary to permit mothers to work their way to a satisfactory decision. If during the waiting period the baby is not cared for by his mother, it is preferable for him to be cared for in a temporary foster-home rather than in an institutional nursery."

On the subject of boarding homes and group care, Bowlby says that the controversy over the merits of foster-home care

and of institutional care can now be regarded as settled. There is no one who now advocates care of children in large groups. Indeed, all advise against it. However, there is widespread agreement regarding the value of small specialized institutions. These have been found to serve best some of the following types of children:

> "(a) The seriously maladjusted child who is unable until improved to make an effective relation to foster-parents. . . .
>
> "(b) Adolescents who are no longer dependent on daily personal care and who, partly because they can so easily maintain an emotional relation with their own parents, even in their absence, do not readily accept strangers in a parental rôle. . . .
>
> "(c) Children over the age of six or seven who are in need of short-term care only.
>
> "(d) Children whose parents feel threatened by the relationship between their child and foster-parents and who may need an interval before deciding whether to take their children back home or to release them to live in a foster-family.
>
> "(e) Large groups of siblings which might otherwise have to be split up among several foster-homes."

Bowlby deplores the fact that in spite of the complete agreement among authorities on the best types of care for young children, a fairly recent and very important British report (Curtis Committee, 1946) recommended residential nurseries for all children up to twelve months. He thinks that any official government policy should oppose residential nurseries and favor the care of infants and young children in foster-homes. In summary he says "that group residential care is always to be avoided for those under about six years, that it is suitable for short-stay children between six and twelve, and for both short-stay and some long-stay adolescents. It is also indispensable for many maladjusted children."

In a two-page "Conclusion," Bowlby offers what might almost be a blueprint for professional workers, voluntary agencies, and governments who are charged with the responsibility for human welfare and the prevention of social breakdown. This final section so succinctly and so powerfully summarizes the thesis of the entire monograph that it seems to be worth quoting in full:

> "The proper care of children deprived of a normal home life can now be seen to be not merely an act of common humanity, but to be essential for the mental and social welfare of a community. For when their care is neglected, as happens in every country of the Western world to-day, they grow up to reproduce themselves. Deprived children, whether in

their own homes or out of them, are a source of social infection as real and serious as are carriers of diphtheria and typhoid. And just as preventive measures have reduced these diseases to negligible proportions, so can determined action greatly reduce the number of deprived children in our midst and the growth of adults liable to produce more of them.

"Yet, so far, no country has tackled this problem seriously. Even in so-called advanced countries there is a tolerance for conditions of bad mental hygiene in nurseries, institutions, and hospitals to a degree which, if paralleled in the field of physical hygiene, would long since have led to public outcry. The break-up of families and the shunting of illegitimates is accepted without demur. The twin problems of neglectful parents and deprived children are viewed fatalistically and left to perpetuate themselves. It seems probable that the main reasons for this fatalism have been three in number: the assumption that a large proportion of these children were orphans and had no relatives; an economic system which from time to time created unrelieved poverty on a scale so great that social workers were powerless to help; and a lack of understanding of psychiatric factors and a consequent impotence in managing cases where they predominate. In many Western countries, however, these three conditions no longer hold, but two others remain which hinder progress. In the first place, there is still a woeful scarcity of social workers skilled in the ability to diagnose the presence of psychiatric factors and to deal with them effectively. From what has been said hitherto, it is evident that unless a social worker has a good understanding of unconscious motivation she will be powerless to deal with many an unmarried mother, many a home which is in danger of breaking up, and many a case of conflict between parent and child. A particularly impressive feature of the past decade has been the extent to which the psychoanalytic approach to case-work has developed in the American schools of social work and the extent to which social agencies are employing child psychiatrists to aid their case-workers. Nevertheless, despite these hopeful signs, there is a tremendous task before all countries to train social workers in appropriate methods and child psychiatrists to aid them.

"The second factor which still operates is a lack of conviction on the part of governments, social agencies, and the public that mother-love in infancy and childhood is as important for mental health as are vitamins and proteins for physical health. This lack of conviction has two roots —emotional and intellectual. A strong prejudice against believing it is not infrequently found in people who are heatedly preoccupied by the alleged inadequacy of children's own parents and who have a conspicuous need, of which they are not always aware, to prove themselves better able to look after the children than can their own parents. Members of committees, too, in contemplating the fruits of their labors, are apt to find more personal satisfaction in visiting an institution and reviewing a docile group of physically well cared for children than in trying to imagine the same children, rather more grubby perhaps, happily playing in their own or foster-homes. One must beware of a vested interest in the institutional care of children!

"The intellectual doubts are more easily dealt with and may perhaps have been influenced by the scientific data reviewed in Part I of this report.

"To those charged with preventive action the present position may be likened to that facing their predecessors responsible for public health a

century ago. Theirs was a great opportunity for ridding their countries of dirt-borne diseases; some took it, others remained hypercritical of the evidence and inert. True, the evidence presented in this report is at many points faulty, many gaps remain unfilled, and critical information is often missing; but it must be remembered that evidence is never complete, that knowledge of truth is always partial, and that to await certainty is to await eternity. Let it be hoped, then, that all over the world men and women in public life will recognize the relation of mental health to maternal care, and will seize their opportunities for promoting courageous and far-reaching reforms."

BOOK REVIEWS

CHILDREN WHO HATE. By Fritz Redl and David Wineman. Glencoe, Illinois: The Free Press, 1951. 250 p.

The authors of this book have had wide experience in work with young delinquents, and although this particular book draws its case illustrations from Pioneer House, a small residence for delinquent boys operated for several years in Detroit, Michigan, the authors' frame of reference is actually much broader. The book is subtitled, *The Disorganization and Breakdown of Behavior Controls,* and this subtitle is more descriptive of the content of the book.

In Chapter III, entitled, *The Ego That Cannot Perform,* the authors organize their discussion under twenty-two different "functions" of the ego. Some of the functions discussed are: frustration tolerance; coping with insecurity, anxiety, and fear; temptation resistance; realism about rules and routines; warfare with time. This original and creative organization makes the book very readable and its broad usefulness is enhanced by the numerous comparisons with normal children and normal processes. This look at the extremes of behavior, as so often happens, enhances one's understanding of the development of the functions of the ego in the more normal child and young person. Often I found the book crystallizing for me information and knowledge that I had derived from experience. A book that can perform this service is invaluable.

In summarizing Chapter III, the authors point out that more research is needed for further clarification and breakdown of the functions of the ego. "One statement, however, we would want to emphasize heavily before we leave this point: No matter how imperfect any given assortment of ego disturbances may be, it is important to begin to break down the vague concept of a 'weak' or 'poorly functioning' ego into many more specific parts than has ever been done before. For our work with disturbed children, as well as for daily ego support for the normal ones, we have to know all the jobs an ego may be summoned to perform in a twenty-four-hour day. . . . to find ways of ego support, we first have to know just what jobs the ego needs to be supported to do. There is no path to a more efficient instrumentology of ego support except the one that leads over a more specific knowledge of just what ego functions are to begin with, and what they look like when disturbed."

In Chapter IV the authors continue with a discussion of the techniques of a delinquent ego, the strategy of evasion, of defense against

change and against the people who attempt to produce change. Again in this chapter the authors remind us that "while the list here constitutes the armory of 'children who hate,' the ego of any child, especially the normally growing pre-adolescent and young adolescent will at times have jobs to perform similar to those his more disturbed contemporaries have on a larger and more chronic scale. This further means that the same basic ingredients of ego defense against educational surrender and change can be observed by all teachers and parents and the technical issues of just how to go about meeting the ego that defends itself against change becomes as relevant as it is for the clinician in a treatment home."

The discussion of the phenomenon of treatment shock in a succeeding chapter and of the task of overcoming this shock raises fascinating theoretical questions—questions that one wants to review in relation to other types of therapeutic situation.

In the concluding chapter, the authors point out basic reasons why these children who hate are not treatable either through good education or through psychiatric treatment. There is no way out of the treatment dilemma but the invention of a new design. The authors promise us further discussion of this design in a forthcoming publication.

The sophisticated consumer of psychiatric literature will find this book full of practical and theoretical questions, but it is so clearly and concisely written that it will be equally useful to any student of human behavior.

FRANCES P. SIMSARIAN.

Washington, D. C.

CHILDREN IN TROUBLE: AN EXPERIMENT IN INSTITUTIONAL CHILD CARE. By Frank J. Cohen. Edited by Hermine I. Popper. New York: W. W. Norton and Company, 1952. 251 p.

Children in Trouble is an attempt by the author to formulate certain principles of institutional care for children. These principles have emerged as the result of his experience at Youth House, which was opened in April, 1944. It is a thoughtful, careful, objective, and thought-provoking job that he has done. He describes a persistent attempt to develop "a non-punitive, non-rewarding method of treating with youngsters who had broken the law, truanted from school, or disrupted family or community life."

The reviewer knows first-hand of some of the difficulties that he met in the attempt to establish in New York City a detention home based upon these principles. This book indicates that tremendous growth has been made in the Youth House project over the past eight years.

It indicates an increasing appreciation of the fact that children vary in the degree to which they can accept affection, love, and external controls. It also indicates that some children are too emotionally disturbed to be able to take group living even in a permissive atmosphere. Their destructive influence on the group and upon other individuals is recognized.

Perhaps one of the most outstanding emphases in the volume is the insistence upon a trained, integrated staff, the importance of cottage parents, supervisors, teachers, recreational group workers, and others being recognized. This is a much more realistic approach than that of earlier days, when a good clinic with adequate personnel was expected to bring about therapeutic miracles.

The author points out that institutional living, no matter how it is administered, is a punishing experience. The children who came to Youth House and the Girls' Camp in New York City were already, for the most part, handicapped by a most unfavorable environment, lack of affection, exposure to conflict, and much unhappiness. The author attempts to show how the institutionalization of such children, pending disposition of their cases, can be made a constructive experience and can be used for gaining real understanding of their basic problems and needs.

Two chapters of the book are devoted to permissiveness, which is defined as patient, non-authoritarian handling. The object of this permissiveness is to encourage self-discipline and to develop internal standards and controls. Always emphasized is the need for recognizing that children's behavior is in terms of the felt needs of the child. Children do what they have to do in response to the constellation of drives and needs inside of themselves and coming to them from the environment.

A realistic caution is given in drawing the distinction between freedom and license. The need for controls, even external controls and supervision, is recognized. Sometimes, active measures have to be taken to remove a child from a group. The author points out the difficulty of practicing permissiveness in dealing with disturbed and difficult children. It is too much to expect that all members of the staff, or even most of them, can always be completely permissive because of their own vulnerability to ego depreciation.

A real effort has been made to formulate procedures for dealing with critical situations that are likely to endanger the workers' controls. This same careful planning for other types of emergencies is indicative of a thoughtful evaluation of problems and needs, in the area of behavior, medical problems, psychiatric problems, and recreational and educational problems.

The difficulty of planning a twenty-four-hour program for children

with short attention spans, restlessness, resentment, anxiety, and lack of wholesome recreational training, is stressed. The integration of the various departments, such as the school, leisure-time, work-assignment, custodial, clinical, and other departments, is described in some detail, as is the coördination and training of the staff, with the development of the manuals and procedures mentioned above.

A method of using social-work staff and clinical workers for dealing with disciplinary problems is described. The non-punitive, non-rewarding bases of the program make this more possible than would be true were such a philosophy not accepted. We wonder how successful the social workers' efforts appear to the custodial and teaching staff. We also wonder what happens during week-ends and other periods when social workers and other professional staff are expected to be off duty.

The medical services are about the same as those found in any progressive institution. The ready accessibility to hospitals in the city obviates the need for some types of medical service that would otherwise have to be provided.

The reviewer was particularly interested in the chapter on the very disturbed child, and the methods of treating such children. Again, the ready accessibility to hospitals with electroencephalograms and other modern diagnostic devices makes it possible to remove the most severely disorganized children from the Youth House. The reviewer would go along with the emphasis in this chapter that children can accept differential treatment for children with different degrees of maladjustment. Children do recognize a deviant in their midst, sometimes before the adults around them do. It is fairly easy to explain the need for special treatment for the deviant.

The participation of children in the development of the recreational, disciplinary, and other parts of the program has been tried before. But the difficulties of doing so in a short-time detention facility has deterred most others from attempting it there. Apparently the author has learned how to use this participation in a most constructive fashion and it has been an invaluable aid to him in overcoming some of the problems that usually arise in such a facility.

What the author has to say about a planned facility, individual bedrooms, convenience for supervision, movement for children, and reception quarters for new admissions, does not appeal to the reviewer as being new or complete. Early studies in this area have been much more carefully done.

According to the author, there are a good many differences between the problems presented by girls in detention and those presented by boys. The problems for which they come in for detention are different. The relationships between the girls are different. The degree of per-

sonalization of everything is much greater with the girls than with the boys. The homosexual interests seem to be stronger. The complaints about the behavior and attitudes of others in the group are much more frequently found in the girls than in the boys.

The author comes to the conclusion that to-morrow's juvenile institution will be "a place of service for children without label"; a place where youngsters will participate in the regulations affecting their conduct; a place where the emphasis will be upon maturing rather than upon good behavior; and where the staff will be selected because of their love of children and their willingness to take continuous training to improve their skills; and where the emotional life of the child will become more important than many of the things now considered important.

The book concludes with six case studies. These studies give the social worker's report, the medical record, the psychologist's examination report, the psychiatrist's report, and recommendations. In reading these case studies, we would like to have had some report of follow-up to determine whether or not the diagnosis and recommendations were followed and whether they proved to be correct.

We believe that the book will be a worth-while addition to the library of institutional personnel, juvenile-court personnel, and others dealing with delinquent and disturbed children.

HERBERT D. WILLIAMS.

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BROTHERS AND SISTERS. By Edith G. Neisser. New York: Harper and Brothers, 1951. 241 p.

The subtitle on the paper jacket of this book tells the reader what to expect from it. With this in mind, the reader will most assuredly not be disappointed. The subtitle is: *How to Deal Sensibly and Constructively With the Normal Jealousy and Friction between Children in the Same Family.* This statement not only describes the nature of the book and its contents—a practical guide for parents and others in charge of young children—but in itself it is an expression of the method advocated by the author—that of preparing children in advance of important events or changes, with frank truthfulness and simplicity of language.

In explaining children's behavior, the author accepts current psychoanalytic theories of psychosexual development and sibling rivalry for parental affection. But the practical suggestions she gives to parents for dealing with little skirmishes and upsets in the family are so full of common sense, backed by a sympathetic understanding of

children's feelings, that they are likely to stand the test of time whether theoretical explanations change or not.

The chapters of the book are introduced by apt quotations from the classics or other literature. This points up the problem to be discussed, be it the arrival of a new baby, open expression of resentment, or resentment in disguise. Then follow one after another fascinating little stories of real people—what they said and did and what kind of behavior had the happiest outcome for everybody. These stories captivate the reader's interest and so provide an excellent medium for conveying good educational principles without recourse to a more didactic method.

To further the practical aim of the book, in addition to the cheerful, nontechnical way in which it is written, the author gives annotated references to other helpful books for parents. Also, in the chapters entitled, *More Fun to be With* and *We're Going to Have a Baby,* she gives the names of books suitable for reading aloud to young children, or picture books about other children for them to look at themselves. Stories and picture books can teach in an indirect, but effective way, by means of "identification," many home truths about happy or not-so-happy family relationships. A few more selected references are given in appendices at the end of the book. There is also an appendix on "Finding Qualified Help for Disturbed Children." This gives information about services for children, such as child-guidance clinics, and where they can be found.

Some readers may feel that the rivalries and jealousies that arise within a family are rather overemphasized. Since the main title of the book is a broad one, *Brothers and Sisters,* one would expect more space to be given to the discussion of affectionate ties between siblings, their genesis and their value in helping children through difficult times in parental relationships. Warm feelings of attachment grow naturally between children, just as some jealousies are bound to arise. The former positive feelings help to dissipate the latter, and are an ally that the parents can count on when they are confronted with the necessity of dealing with temporary frictions.

Extreme dependence of younger children on older ones, close ties between twins, and the "ganging up" of several children in a family as a form of protest are dealt with in the book. Among the causes suggested are insecurity of status, resentment, and rivalry for parental affection. Alternative ways of handling such situations are given, to the end of fostering friendliness, loyalty, and happy relationships between all members of the family.

Within the narrower limit set by the descriptive subtitle on the jacket, the book should be of practical assistance to parents, teachers, and group leaders. It should help them to understand brothers' and

sisters' feelings about one another and their parents. It shows specific ways in which adults may create an atmosphere in the home or school that not only will minimize undue rivalry and resentment, but will contribute to the development of each child's personality and harmonious interpersonal relations.

KATHARINE M. BANHAM.
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AN INTRODUCTION TO CHILD STUDY. By Ruth Strang. Third Edition. New York: The Macmillan Company, 1951. 705 p.

The publication of a third edition of any book indicates the success of an idea. In the case of Dr. Strang's text, the basic idea is its surprising simplicity and clarity, its presentation of what is fact, and its avoidance of fanciful theorizing. The author has revised the previous edition by (1) a presentation of information about characteristic sequences of behavior and also variations from expected behavior; (2) a discussion of possible causes and explanations of children's behavior; (3) a description and explanation of how children learn; (4) a description of conditions that are conducive to wholesome child and adolescent development; (5) instructions in methods of child study and guidance, including suggestions for obtaining practical experience with children and adolescents; and (6) additional references to books, articles, and films that will broaden the understanding of children.

The author indicates that the method of presenting facts is primarily analytical, not prescriptive. Whenever possible, a situation is analyzed so as to clarify the conditions and relations that may be involved and to provide a background for warranted generalization. Dr. Strang views the family "as a positive factor," with emphasis on the potentialities of parents rather than on their faults. Problems are viewed as the child's effort to meet difficult situations; independence, stubbornness, and other behavior annoying to parents and teachers are recognized at certain ages as manifestations of maturity. The emphasis is on "developmental tasks" rather than on "problems" (*Introduction,* p. vii).

The book is divided into six parts: (1) *The Roots of Behavior (Hereditary and Prenatal Influences);* (2) *Early Preschool Period, (The First Two Years);* (3) *The Preschool Period (Years Three, Four, and Five);* (4) *The Primary Period;* (5) *From the Primary Period to Adolescence;* and (6) *The Adolescent Years.*

A well-chosen bibliography is attached to each of these subdivisions. An adequate index, both of authors and of subjects, is also included.

It is of interest that Freud is referred to only once: "Aggression" in young children is not the destructive force described by Freud; it is

a "moving forward," a "constructive and normal way of using energy" (p. 243).

The problem of hostility is briefly, but adequately handled, and the danger of setting no limits to a child's aggressive behavior is stressed. ("A child who is allowed to do exactly as he likes tends to become an anxious child." Cited from Fairbavin, 1939.)

Although Dr. Strang's text is simply and clearly written, it does not oversimplify facts. It is a pluralistic account of human behavior as it grows and develops, and never becomes a biased account of a "school of thought." It is an excellent example of what Adolf Meyer called "common sense."

There is a refreshing directness in the author's comments; thus she writes, "We just don't know what children's drawings mean unless they tell us" (p. 181). "If parents keep obviously trying to improve the child's behavior, he may get the idea that he is unacceptable as a person" (p. 217). Dr. Strang advises that, if there is a death in the family, "it is usually better for the child to share the experience with the persons he loves than to be sent away until the funeral is over only to return with unanswered questions" (p. 171).

She never loses sight of the child's point of view and his basic needs. She properly points out that to "give children affection," the rule that child psychologists state so glibly, is not so simple and easy as it sounds. She states that the child's problem is to adjust to the reasonable demands of his environment without love or self-esteem. The way restrictions are introduced makes all the difference, whether with sympathy, understanding, support, and encouragement, or with harshness, arbitrariness, and threats. And, again, "Parents may play any one of three rôles: (a) They may make demands upon the child that he is ready and able to meet at a given time; in this way they further his development. (b) They may make excessive and unsuitable demands that evoke the child's aggressive tendencies or cause him to feel paralysed by constant failure. (c) They may become slaves to the child's wishes and thus deprive him of the training necessary for him to take his place in the social group."

In these days of "schools," of psychological thought and many varieties of clinical practice, it is refreshing to read a text that is unbiased, matter-of-fact, and sound. Dr. Strang's book can be highly recommended to parents and to every student of child study.

J. H. Conn.

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Baltimore, Maryland.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Vol. 6. Edited by Ruth S. Eissler and others. New York: International Universities Press, 1951. 398 p.

This volume is an interesting and noteworthy contribution to contemporary educational practices. The first sections are an innovation, consisting of a central theme with discussants whose contributions, unfortunately, have not been included. The emphasis is on ample time for give-and-take.

This practice arises from and is an evolution of the workshop idea, which in the United States has been reanimated, if not introduced, by progressive-education methods. There is usually a main speaker, with others who contribute variations of his theme. Ideally, a number of days are devoted to this type of scientific exchange, and the opportunity for discussion from the floor by others is encouraged and a vital part of the symposium. It is essential to have enough time to permit both senior and junior practitioners to participate and to polish their concepts. A successful symposium implies the provocation of new ideas and a sedimentation of current practices, with an opportunity for the free exchange of ideas, free discussion, and social impact.

The first example of such a symposium in the volume under review is the "Anna Freud meeting" at Stockbridge, Massachusetts, in April, 1950, on "Problems of Child Development." This impresses one as being an ideal precedent, and when one looks through the list of participants, one hopes that the exchange will lead to a full report and that a monograph will eventually result from it.

The second example of this type of exchange is the chapter on "Problems of Masturbation." Its inclusiveness is praiseworthy. Here the element of audience participation is not so active; it represents a transition from the formal academic paper reading, with one or two discussants and a comparatively limited audience participation. Each of these types was conditioned, of course, by the circumstances under which it was held; the Stockbridge meeting was for a comparatively limited group with ample time, while the second symposium, held at the New York Psychoanalytic Society, was a departure from the usual single meeting devoted to a particular topic. Certainly, the list of participants is impressive and the contributions in many instances outstanding.

The second section of the volume exemplifies the traditional approach in a series of papers centered around psychological eras: early childhood, the latency period, and adolescence. Some of these aspects were discussed in the workshop also and, therefore, the line of demarcation is not sharp and complete; rather, there is considerable

overlapping of these two approaches, as in the evolution of infantile sexuality.

In the Stockbridge papers, Ernst Kris illuminatingly breaks ground by reviewing past and contemporary research trends in child psychology. His investigation of the many fields of approach is fitting in a philosophy that reviews not only the sound values of past and contemporary literature, but also some of the shortcomings of these approaches. It is a stimulus to desirable set-ups for future investigations. Kris calls attention to the fact that "the advantages of the residential nurseries to which we owe so much, as compared to observation in day nurseries and kindergarten, are obvious. And yet the artificiality of the extrafamilial set-up implies naturally its limitations." His emphasis upon "behavior constancy" and "regression rate" are interesting yardsticks for the evaluation of growth and resiliency.

When Anna Freud takes over and adds her rich experience in private practice and in the Hampstead Nurseries, we are reminded how much the trend in England is toward the child-guidance unit. With a wealth of illustrations and confirmations of libido development, she stresses, among numerous observations, the wide overlapping between the oral and the anal stage, and notes that the line of demarcation between anal and phallic interests seems in comparison to be much sharper.

There is also valuable guidance upon building up the emotional side of children whose aggressive drives are stronger than normal, instead of meeting aggression with aggression. The telescoping of experience in memories, and the confirmation of the fact that a single memory often covers repeated acts are brought to our attention. There are many aspects to her paper which require constant rereading for proper appreciation of their wide implication. We are made aware that the Œdipus reaction has to be worked out in the child left without parents, too.

Dorothy T. Burlingham broadens the concept of parent and child concomitantly under therapy, and some light is shed on the nature of the transference phenomenon in the child under analysis when the mother is undergoing psychotherapy. There seems to be an issue here worthy of further investigation because of the work done by Melitta Sperling.

Marian C. Putnam, Beata Rank, and Samuel Kaplan present a case that involves psychiatrist, psychoanalyst, and pediatrician, and the observations of the child's nursery-school teacher, and that, in actuality, represents the depth approach to the application of child-guidance practices by a pooling of psychoanalytically oriented personnel.

The original contribution of Victor Tausk was paraphrased by

Annie Reich. It is interesting to see how many of Tausk's evaluations are still valid, and how the findings of Ernst Kris and Milton I. Levine elaborate on the current spreading and growing knowledge of the problem of masturbation. Levine strikes a new note and a very important one in his evaluation of this psychoanalytic knowledge and its application in current pediatric practice, and he notes how much these early observations have influenced our recommendations to parents in handling this universal problem with less tension and more understanding.

The section on early childhood was introduced by Anna Freud in her collaboration with Sophie Dann in an experiment in group upbringing with six young children of German-Jewish background, victims of the Hitler régime and without parents since soon after birth. The initial group solidarity, with resistance to adult relationships, gives way slowly, when security has been attained, to sibling rivalry, something that formerly was nonexistent, for adults were outsiders to the group. Interesting observations on orality and toilet habits are brought home to us, too.

Following the Freud-Dann chapter are individual papers: M. Wulff's on "The Problem of Neurotic Manifestations in Children of Pre-Œdipal Age"; Phyllis Greenacre's evaluation of early elements which manifest themselves in adult symptomatology; Marjorie Harley's *Analysis of a Disturbed 3½ Year-Old Boy;* and Charles Brenner's *A Case of Childhood Hallucinosis.* The interesting core of these papers is the definite evidence of psychopathology firmly organized into symptomatic manifestations at a very early age. Phobias and hysterias are observed, together with nascent obsessional neuroses, in these early manifestations.

The section on early childhood is rounded out with interesting notes by Dorothy T. Burlingham on pre-psychoanalytic ideas about children in the sixteenth and seventeenth centuries. The terminal paper in this section is by Rene A. Spitz on "Psychogenic Diseases in Infancy," which is in actuality a condensed and most helpful summation of much of his work for the last years on this period of growth. It is an invaluable index to therapy, not alone to psychiatrists, but to pediatricians. One might aptly say that these are the earliest manifestations of psychosomatic entities.

The section on "Latency" is opened by Berta Bornstein, who begins with the resolution of the Œdipus complex and the establishment and growth of the superego and ego. A heightened ambivalence marks this period, and the type of phobia changes. The prevalence of insomnia is more frequent than is generally appreciated. The transference is particularly delicate because of the child's inherent distrust,

ambivalence toward adults, and uneasiness at his enmity to the analyst. The reënforcement of the ego is a technical aim, and the utilization of free associations, play, drawings, and stories is employed, all with modifications, however. This information gives us a knowledge of the child and is a stepping-stone in the analysis of defenses and effects during the latency period.

Selma H. Fraiberg has two articles—one on the nature of the transference in child analysis, in which she brings out the differences in the transference phenomena between adults and children. The transference neurosis as such is not clear, as it is in adult analysis. There are subtle differences because of the realistic rôle of the parents. The second article, on "Englightenment and Confusion," is a most significant contribution, for in it is implied much more than is appreciated at first. The whole problem of education, the so-called enlightenment of children—not alone in regard to sex, but to other facts—is a matter of timing and our success or failure is not determined so much by the knowledge of the educator as by the receptivity of the learner. Time and time again, as Miss Fraiberg points out, we are sure that we have clarified certain aspects of knowledge, in our work with children, to find later on that this has been twisted and molded to meet the immediate needs of the child. This comparatively short article is worthy of note because interpretation in therapy, like all enlightenment about the facts of life, is subject to rules laid down by the unconscious of the recipient rather than by his intelligence.

The last section, on "Adolescence," includes an anthropological evaluation, by Jacob A. Arlow, of an adolescent rite among Jews called "Bar Mitzvah." The volume is rounded out with a review by Leo A. Spiegel of the psychoanalytic theory of adolescence, which reveals how much still remains to be done in this field and how rigid our concepts of adolescence are, for far beyond the recrudescence of the Œdipus and its implications is the question of superego guidance of the sexual drive in cases in which sexual maturation, as in our culture, is characterized by a long interval before consummation is socially acceptable. One is impressed by the responsibilities of the therapist here, for the adolescent stands midway between dependence and independence, more so than individuals of any other age.

The spread in the practice of psychoanalytic therapy of children between this country and abroad is much narrower than it was and the cross-fertilization of ideas is well advanced. We need more intercontinental workshops to bring to fruition a process well begun.

EDWARD LISS

New York City

FATHERS ARE PARENTS TOO. A CONSTRUCTIVE GUIDE TO SUCCESSFUL FATHERHOOD. By O. Spurgeon English, M.D., and Constance J. Foster. New York: G. P. Putnam's Sons, 1951. 304 p.

The greater part of this book is devoted to a discussion of the problems of the developmental phases in children from birth through adolescence. Based on psychoanalytic insights, it is written for the layman who has already acquired some preliminary understanding and acceptance of the dynamic principles of behavior.

Using the concepts of psychoanalytic developmental theory as a text, the authors present a plea to fathers to be better parents, and warn them, in behalf of the mental health of their children, not to neglect the obligations and responsibilities of fatherhood. Although the authors conjure up the scarecrow of psychopathology, there is enough understanding presentation of healthy aspects of personality development in children to serve as an effective and reassuring counterbalance.

On the whole, the tone of the book is kindly, and the warmth and friendliness of the authors emerge consistently and positively. The discussion of what fathers can do in a practical way to meet the challenge of their children's dilemmas is thoughtful, and almost always couched in concrete and intelligible language. One would have no hestitation in recommending this book to a moderately sophisticated male parent seeking a "constructive guide to successful fatherhood."

JULES V. COLEMAN.

New Haven, Connecticut

GROWTH AND CULTURE. A PHOTOGRAPHIC STUDY OF BALINESE CHILDHOOD. By Margaret Mead and Frances Cooke MacGregor. (Based upon photographs, by Gregory Bateson, analyzed in general categories.) New York: G. P. Putnam's Sons, 1951. 223 p.

This book is the second publication reporting on research by Bateson and Mead in Bali, where, between 1936 and 1939, Bateson took 25,000 photographs of Balinese. In preparing the material for this book, 4,000 of the photographs were analyzed. Dr. Arnold Gesell, Dr. Frances Ilg, and Dr. Louise Ames collaborated in analyzing the photographs and selecting and arranging the 380 that are reproduced. Thus the present volume and the well-known Gesell Atlas and other studies from the Yale Child Development Clinic may be used to compare the growth and development of children in our culture and in Balinese culture.

The 380 photographs reproduced in this study are mostly of eight children. In 16 pages of pictures, the children are shown at successive stages of development, from a few weeks or months of age up to two or

three years. The other 42 picture pages show the Balinese manner of sleeping, suckling, feeding, and bathing; the development of the children in creeping, standing, walking, and other motor activities; the ways in which Balinese infants are handled by adults and older children; and so on. All of the pictures are accompanied by an explanatory text. This combination of pictorial and explanatory material, together with a brief statement of conclusions, comprises Part II of the book, which is the largest part, occupying pages 55 to 186.

Part I (pages 2 to 52) consists of three chapters written by Margaret Mead. The first discusses a number of general topics, including observations on parental resistances to and misinterpretations of scientific studies of child development. Chapter II gives an excellent presentation of the complex problems involved in scientific research on child development, which must take into account not only the innate capacities for growth, but also the influence of various cultural situations upon growth patterns. Chapter III considers aspects of the cultural setting in which Balinese infants and children develop.

Besides the material briefly described above, there are appendixes (pages 189–218) outlining the steps involved in the research, and giving bibliographical references. There is also an index-glossary.

PHYLLIS BLANCHARD.

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YOU AND YOUR AGING PARENTS. By Edith M. Stern with Mabel Ross, M.D. New York: A. A. Wyn, 1952. 212 p.

Edith Stern has written a number of practical books which have been used extensively in the mental-hygiene field. Her latest book, this time in collaboration with Mabel Ross, M.D., might suitably be called, *You and Your Aging Parents, Friends, or Relatives,* for this very practical, human little volume offers suggestions that are of value to any of us in our understanding of the difficulties that many older people face in making the necessary readjustments to the changes that come in their lives.

One of the most useful things about this book is that not only does it point out issues, and the possible involvements in making a decision one way or another, but it offers suggestions as to what to say to make the discussion of the situation easier for all concerned. When we are emotionally involved, it is hard for us to think through just what we should say and the most auspicious time for saying it. Thus the leads given are particularly helpful.

While the book is primarily concerned with the relationships between sons and daughters and their aging parents, the situations presented and the individual adjustments required are common to

most older people, so it is of use to all of us as we come in contact with aging people.

Those who are old who read this book will see in Mrs. Stern and Dr. Ross understanding allies. Those who are young will gain deeper understanding of how difficult it is for the older person to find the satisfactions necessary to replace those he had when he felt needed, important, and productive, and to reconcile him to the rapid and drastic changes that frequently take place in his life when he may feel least prepared to meet them.

With this understanding, younger people will be more tolerant and more helpful in maintaining the mental health of older people.

It is a well-timed book, vividly written. After you have read it, you will want to recommend it to many of your colleagues, friends, and relatives.

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THE PRACTICE OF MARRIAGE COUNSELING. By Emily Hartshorne Mudd. New York: Association Press, 1951. 336 p.

The author of this book is the well-known director of the Marriage Council of Philadelphia. Composed after fifteen years of experience in the field, the book is largely based upon the characteristics and problems of 2,559 men and women who came to the council for help. As the author presents the methods, philosophy, and procedure of marriage counseling, many case histories illustrate the most typical problem areas.

The book will be especially helpful to pastors, to whom many people come for counsel in marital difficulties. Since many of the clergy have had little academic training in this specialized field, they will find the book an indispensable guide. But it must be said also that psychiatrists and physicians, as well as laymen to whom people come with their problems, need the guidance this book offers; it will be helpful even to the expert counselor.

The book starts with the story of the development of marriage counseling, which is a comparatively recent advance in the approach to interpersonal problems. This is followed by a discussion of current events as they effect marriage and marriage counseling—the economic depression, the accelerated change that followed it, and the war years.

The third chapter deals with less formalized marriage counseling as it is practiced by physicians, clergymen, educators, and other individuals. In this section of the book, certain basic principles are stated. Along with these there are specific suggestions that will be

helpful to the expert as well as to the amateur, who often finds himself acting as a marriage counselor whether he wants to be one or not.

This reviewer has never before read such a complete coverage of marriage-counseling organization and facilities as that in the fourth chapter, which clearly explains how these various organizations function independently and interprofessionally.

On the basis of all this information, the author prepares the reader for the consideration of the clients of a marriage council. Who are they? Why do they come? What are their specific characteristics and problems? All of these questions are treated graphically and concisely, with tables and graphs that give the reader the picture he wants. Actual case histories are presented, interview by interview, reflecting the periods before, during, and after World War II. Step by step, the reader is taken through the process of counseling. The last chapter brings the book up to the present, dealing with the impact of mobilization and war on clients of the Marriage Counsel.

The bibliography, which is unusually complete, and the two appendices require about one hundred pages, but they are worth that amount of space. Appendix A lists the national and local organizations that deal with marriage counseling and gives their names and addresses. This list is classified according to states and names the director of each, the executive secretary, or the chairman. Appendix B contains reports from functioning services as furnished by their executives from October, 1950, to April, 1951.

The book demonstrates how interesting a difficult subject can be made by one who has the ability to write. It contains a vast amount of information that could be gathered only by one who has been in the field over a period of years. Because of this, it will become a standard reference work on marriage counseling. It should be read and studied by every one, regardless of previous training, who engages in marriage counseling.

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PREDICTING ADJUSTMENT IN MARRIAGE: A COMPARISON OF A DIVORCED AND A HAPPILY MARRIED GROUP. By Harvey J. Locke. New York: Henry Holt and Company, 1951. 407 p.

One of the requirements of science is that the seal of approval be withheld from any conclusions of researchers until they are confirmed by repeated independent investigations. In the process of checking the results of predecessors, researchers not only test old conclusions, but often uncover new leads which may become, when tested in turn by

others, new knowledge. In this way, knowledge in a given area accumulates, and the accumulated knowledge makes further discovery more likely.

Sociology is a relatively young science, and its youth is perhaps evident in the great mass of uncoördinated and uncorroborated studies that constitute so much of its literature. But sociology is coming of age, and one of the signs of its maturity is the concern of investigators with (a) confirmation of the findings of predecessors, and (b) additions to the stockpile of knowledge in certain areas.

Probably few, if any, topics in sociology have been subject to more scientifically fruitful analysis than conditions affecting success or failure in marriage. This problem has had the benefit of a succession of studies which have tested earlier conclusions while enlarging the area of knowledge. One of the latest productions in the field is the book under review, Harvey Locke's *Predicting Adjustment in Marriage: A Comparison of a Divorced and a Happily Married Group,* which adds to the previous studies by Bernard, Davis, Hamilton, Hart, Kelley, Kirkpatrick, Landis and Landis, Schroeder, Winch, and especially Terman, Terman and Odum, and Burgess and Cottrell.

Locke's study is unique in its sample, which (a) includes 201 divorced couples plus 123 divorced persons whose mates were not interviewed, all compared with 200 happily married couples; and (b) is more representative of the general population than the samples used in previous studies. Locke's group was obtained from a county in Indiana. Information was secured by personal interview, using a questionnaire built on questions used in previous marital prediction studies, but adding thereto.

Readers of MENTAL HYGIENE will be interested in some of the conclusions that confirm previous findings. While no relationship is found between the presence or absence of children, or size of family, and marital adjustment, marital adjustment is found to be related to the desire for children. Marital happiness is associated with executive ability, as manifested by the ready acceptance of responsibility, leadership, the ability to make decisions readily, determination, and not being easily influenced by others. General personal adaptability, as evidenced by such traits as yielding in arguments, not being dominating, and control of anger, are also related to marital happiness, as are sociability, conventionality, and the capacity to give and receive affection.

On the negative side, Locke found no relationship between marital adjustment and attachment to father or mother, whereas both Terman and Burgess had reported such a relationship. Burgess found health to be associated with marital happiness in the case of the husband, but Locke found no such relationship. Locke's subjects fared best if they

were married at home, whereas Burgess's did better if they were married at church or parsonage, although in both studies marriage by a representative of a church was a favorable factor. Locke presents a comparison of his findings with those of other studies in Table 55, pages 342–57.

One of the virtues of this study is the fact that the author is mindful of its limitations. A serious problem of all studies in the field to date is that the correlations between background factors, personality, sex, and marital happiness are generally less than .5, which means that about three-fourths of the factors affecting happiness are not accounted for. Higher correlations may perhaps be found when traits of husbands and wives are dealt with not separately, but in combination, and, better still, when constellations of traits in one spouse are considered in relation to constellations of traits in the other spouse. Locke closes his book with a number of suggestions whereby the research in this area may be improved.

M. F. NIMKOFF

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PERSONALITY AND PSYCHOTHERAPY. By John Dollard and Neal E. Miller. New York: McGraw-Hill Book Company, 1950. 488 p.

This book, dedicated to "Freud and Pavlov and their Students," is no book to be recommended to any but the most serious students of behavior theory. In common with most treaties on psychology, it tends to be repetitious and pedantic, but this apparently is considered the necessary approach to the presentation of the gestation and delivery of an idea.

The authors have performed a seemingly impossible task—that of taking orthodox Freudian concepts apart and reshuffling them in such a way as to make them essentially conform with Pavlovian concepts of conditioned responses. These in turn are fitted together into a pattern that bears out the authors' theory of learning.

They hold that neuroses are learned just as other behavior is learned, and that the process of psychotherapy is an unlearning and reconditioning or reëducating process in which the higher intellectual faculties (labeling) must take part if there is to be any permanent and "generalized" value to the patient. Whereas there are only a few places in the book where there is expressed difference with Freud, the approach that the authors constantly stress in practice implies material difference from that of Freud and his disciples, particularly in their attention to the patient's present circumstances and their emphasis on inclusion of the totality of the patient's life.

Though no mention is made of H. S. Sullivan, it would seem that there is a closer similarity between the authors' concept of transference

and Sullivan's parataxic reactions than between theirs and Freud's. Aside from Freud, the chief references to psychiatrists are to Alexander and French and to Grinker and Spiegel, from whom they quote liberally.

Despite the authors' claim that they have merely begun the work of correlating psychopathology and psychodynamics with learning theory, there is no doubt that they have made a genuine contribution.

There are many small details with which one might disagree, but there are also many more that are provocative and interesting. Some of these are the correlation of the unconscious with the non-verbal (unlabeled), the basis of bizarre pathology in a childhood devoid of patterns of reality testing and cross-checking, and the belief that the mind of the child can deal with emotional problems if only the adults can lead the way, to the end of accomplishing prevention of adult psychopathology. In view of my own contention[1] that every one is neurotic, not merely those with crippling symptomatology, I enjoyed especially their reference (p. 431) to the normal person as "one who has not been adequately studied." Chapter X, *Social Conditions for the Learning of Unconscious Conflicts,* is especially good.

The first half of the book is devoted to establishing the theory of learning along Pavlovian lines and applying it to psychopathologic entities. The second half in concerned with therapy and the dynamics of recovery or of failure to recover. Any beginner in psychotherapy could read it with profit, not only for assistance with theory, but for practical suggestions in the conduct of therapy. There is even a section devoted to the qualifications of a therapist. In fact, the main criticism of the book seems to me to be that it is too comprehensive. For those who want even more, there is an extensive bibliography.

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PERCEPTION: AN APPROACH TO PERSONALITY. Edited by Robert R. Blake and Glenn V. Ramsey. New York: The Ronald Press, 1951. 442 p.

How does man "know" the objects of his environment? How does one man come to know another man? Why do things look as they do? Does the world register on each person in about the same way? What are the determinants of the different ways in which individuals react to their physical and social surroundings?

[1] See *Saints, Sinners, and Psychiatry,* by Camilla Anderson. Philadelphia: J. B. Lippincott Company, 1950.

This book is concerned with a systematic examination of such questions. It is composed of thirteen papers by eminent specialists from a dozen research centers, reporting on the advances that are being made in the perceptual approach to personality. The papers were originally delivered at the 1949–1950 Clinical Psychology Symposium held at the University of Texas, the underlying theme being that the study of perceptual activity provides a basic approach to an understanding of personality and interpersonal relations. Perceptual activity supplies the materials from which the individual constructs his own personally meaningful environment. This concept is employed as the frame of reference for interpreting and interrelating data from many diverse fields of personality investigation.

The physical characteristics of the perceiving system are considered as the *structural* determinants. The conditions that determine the individual's instrumental utilizations of these structures in specific stimulus fields are viewed as the *experiential* determinants, since they stem not only from the individual's given physical structure, but also from the contributions and limitations imposed on it by experience. These two are considered as inextricably interconnected; each experience modifies the reaction potentialities of the structure; the modified structure is then set to define the next related stimulus configuration in a characteristic way and is in turn modified by subsequent definitions.

Under structural determinants in perceptual activity, anatomical factors are treated by Clifford T. Morgan, who examines the basic machinery by which "experience" is incorporated into the nervous system. He concerns himself with the question of what the sense organs are like, how the sensory systems of the body are built and function, and how the brain works in perception. Chemical factors are discussed by Frank A. Beach, who develops a threefold approach to the problem, surveying "the various types of evidence that demonstrate the existence of relationships between particular alterations in body chemistry and specific changes in behavior. The second aim is to discuss and evaluate possible explanations for these relationships. The third objective is to explore the major questions confronting specialists in the field and to determine, if possible, what procedures are most likely to provide us with solutions to these problems."

The consideration of experiential determinants of perceptual activity includes a treatment of the rôle of learning in perception, by Ernest R. Hilgard, who discusses the problem of how the events occurring in the individual's stimulus fields are incorporated into the organism. Jerome S. Bruner presents an outline for a theory of perception in which he interprets much of the recent research, suggesting the manner in which personality dynamics may serve to set the selection of

information from the environment and, consequently, to determine important aspects of adjustment. A consideration of the ingredients of culture, which molds and determines the set of the perceiver at any moment of interaction, is offered by Wayne Dennis. Following this is an analysis by the late Alfred Korzybski of the rôle of language in structuring perceptual activity.

A review of the points of agreement and divergency in the writings of five foremost personality theorists—Freud, Lewin, Rank, McDougall, and Sullivan—is undertaken by Urie Bronfenbrenner, who then summarizes the significant and persistent ideas about the development of the self system into a series of propositions under the two heads of "personality structure" and "personality development."

James G. Miller deals with unconscious factors in perception. He considers "the psychology of ignorance—how the individual deals with gaps in his knowledge." The field of behavior pathology as related to and derived from normal biosocial behavior is discussed by Norman Cameron.

The rôle of perception in psychotherapy is treated by Carl Rogers, who presents the evidence touching on the changes that come about in perception of the environment and the self by clients, and proposes a theory of psychotherapy that emphasizes the perceptual elements in the process. George S. Klein develops an approach to the problem of understanding a person's organization through investigating his perceptual activity by describing three basic perceptual attitudes, relating to them a body of research findings from studies at the Menninger Foundation and developing an outline through which to represent the idea of an ego-control system. The task of relating perceptual research to the more inclusive body of concepts and principles about the organization of personality is undertaken by Else Frenkel-Brunswik, who lays a foundation upon which a rapprochement between hitherto disparate areas may take place.

Such an abundance of new material is coming to hand from experimental psychology and clinical psychology regarding the dynamics of perception that this attempt at integration should be particularly welcome to clinical psychologists and psychiatrists, who find it increasingly difficult to devote the necessary time from the press of service duties to familiarize themselves with current research. Although the book is intended for use in upper-level courses in perception, personality, and experimental clinical and social psychology, this reviewer agrees with the editors that students in neighboring disciplines can refer to it for information and integrative concepts.

SIDNEY YUDIN

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THE EGO AND THE SELF. By Percival M. Symonds. New York: Appleton-Century-Crofts, 1951. 229 p.

For some time I have wished that I could find a book in which the facts established by the academic and experimental psychologists would be integrated with the facts discovered through psychoanalytic research. Dr. Symonds has done this in respect to the ego and done it very well. He defines the ego—or, as he prefers actually to call it, the ego processes—as that part of the personality which determines the adjustment to the outside world in the interest of satisfying inner needs in those situations in which choice or decision is involved. These ego processes may be conscious, preconscious, or unconscious. He discusses in a very clear and understandable way, with many examples to illustrate each point, the structure, functions, and development of the ego; the concepts of ego strength and ego weakness; and the rôle and place of the ego in pathological states, in psychotherapy, and in education.

He also discusses the concept of the self, which he defines as the body and mind and as the bodily and mental processes as they are observed and reacted to by the individual. Usually these processes are conscious. As in his consideration of the ego, he discusses the development of the self, the concept of self-feeling and self-evaluation, and the place of the self in psychotherapy and in education. This concept of the self, whether it be topographically a part of the ego or of the superego, is a valuable one and has not been emphasized enough in the psychoanalytic literature.

Partly for the reason that he includes a full discussion of the concept of the self, partly because, as I said earlier, Dr. Symonds has brought together the facts from academic and experimental psychology and from psychoanalytic research, but more because of the clarity of his presentation of the structure and functions of the ego, I would recommend that this book be read by every student in psychoanalysis as an introduction to more detailed studies on the ego, for most students in psychoanalytic learning are woefully ignorant of the contributions to psychology that have been made by the psychologists. I would recommend it also to students in psychology, who usually are equally ignorant of the contributions made by psychoanalysis to the understanding of the human mind.

Although I feel that this book is a valuable contribution as an introduction to the more detailed study of the ego, there is no book that has not some defects. Dr. Symonds does not present at all adequately the mechanisms of defense which are one of the most important functions of the ego and, to my mind, are not only of great importance in psychoanalytic psychotherapy—as Dr. Symonds states—but are

going to become increasingly important both for the theoretical and for the practical understanding of the processes of learning and of the education of children. I regret that Dr. Symonds did not pay more attention to this.

With two statements I do not agree. Dr. Symonds states that repression is not found if the ego is healthy. For this statement he quotes Dr. Franz Alexander. I don't remember Dr. Alexander's saying this, but even on the basis of Dr. Alexander's authority, I believe that the statement is inaccurate. Frequently in psychoanalysis one finds that the patient's neurosis has resulted in the return of the repressed—*i.e.*, the repression has broken down—and one of the tasks of the analysis is to develop a healthy repression—for repression is a valuable mechanism of the healthy ego.

I believe that Dr. Symonds is a bit in error when he includes extension of ego boundaries as a form of depersonalization. Again he falls into this error because of lack of consideration of the mechanisms of defense. Extension of ego boundaries seems to me to occur as an expression of one of two defense mechanisms—appersonation as described by Sperling and altruistic surrender described by Miss Anna Freud—or as the result of an imperfect development of object relationship such as occurs in childhood psychoses.

In my opinion the last three chapters are too brief to be adequate.

Although I may seem to have emphasized these criticisms, they do not change my opinion as to the great value of this book.

The bibliography is excellent.

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SELF-CONSISTENCY: A THEORY OF PERSONALITY. By Prescott Lecky. Edited and interpreted by Frederick C. Thorne, M.D. New York: Island Press, 1951. 275 p.

It is difficult to review this posthumous publication because it is in reality two books. The first is made up of a brief core of material gleaned from the largely unpublished writings of Mr. Lecky; the second gives the interpretations by Dr. Thorne, who edited this second edition. It is difficult to evaluate the worth of Lecky's work because of editorial generosity and some confusion as to just who contributed what sections.

Dr. Thorne's biographical sketch of Lecky does not reveal a happy man. As a matter of fact, it might be said he was a victim of his own self-consistency. He did not adapt well to the scholastic work of Columbia University between 1924 and the time of his premature

death by coronary thrombosis in 1941. He was never quite able to perfect the methods and material discussed here, his doctoral-thesis material, to his own satisfaction, and this served further to hide his professional talents. He was appreciated and understood by only a few students, one of whom became the editor of this book.

By self-consistency Lecky appears to mean the powerful tendency of an organism to preserve intact its holistic organization in a harmonious, consistent, and integrated fashion. There is an (unstated) analogy between behavior here at the socio-psychological level, and the physiological self-consistency of Claude Bernard and Walter Cannon. Lecky's cogent arguments against behavioristic and mechanistic psychologies now seem unnecessary, but they do indicate how dominant these disciplines were in the pre-clinical psychology of two decades ago.

Read in the current *Zeitgeist*, there is nothing particularly startling in Lecky's views. It now seems self-evident that children and adults alike are happier and more comfortable when in an environment that permits a consistent and not too stressful mode of life. Similarly, our notions about ourselves (as kindly, honest, inferior, happy, etc.) do affect our day-to-day behavior. Anxiety, for example, is a result of not being able to achieve self-consistency. Lecky's clinical work appears to have been mostly with children and college students and with academic problems, and the book does not deal with acutely disturbed individuals. His psychiatric leanings are largely Adlerian and he has a curious habit of both attacking Freud and using his concepts as his standard of comparison.

An important chapter deals with the "Individuality Record," a collection of some 200 questions in personality-test form selected to represent a fair sampling of life situations. The answers of 500 college freshmen to these questions and the statistical treatment thereof constitute the basic data for the self-consistency theory, in which it is suggested that one's ideas of one's self are the nuclear or core components, with new ideas, and their relations to other persons and places, the outer layer. Analogous to dynamic concepts of the atom, positive and negative concepts of the self are visualized as distributed about the nucleus, distance being the function of the importance of such ideas to self. The third dimension results from time.

It is only through patient submission to this latter inexorable dimension that a man's contributions may be judged. This is facilitated by having a clear statement of data and theory, and Dr. Thorne has performed a service in aiding such a presentation.

With all due respect to the author and to his pupil, and with a desire to be gentle to a posthumous publication, it is my opinion that

Mr. Lecky's concept might have been presented in a much shorter outline.

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LEARNING THEORY AND PERSONALITY DYNAMICS. By O. Hobart Mowrer. New York: The Ronald Press, 1950. 776 p.

Its subtitle, *Selected Papers,* designates correctly the nature of this volume. It consists of 24 chapters, all but eight of which have been published previously as separate articles or monographs. The book does not represent an explicitly stated unified theory of personality, but rather a series of studies on such subjects as the author considers important for an understanding of personality dynamics and for practical clinical applications. There is an attempt to create a certain unity through the sequence in which the chapters are arranged and through brief annotations that are aimed at connecting the various studies.

The book consists of two parts. Part I deals with learning theory, Part II with personality dynamics. The author considers learning theory as being of central importance "for the better understanding and more efficient practical management of the many problems involved in psychotherapy," though he admits that "learning theory is still far too simple to encompass all the complexities of socialization and character formation."

The author's views on learning theory are based on the findings of his laboratory experiments with animals. He has made careful experimental studies of the problem of anxiety which he, also as a clinician, regards as a central problem for the understanding of neurotic behavior.

In the first part of the book the author traces his development from the assumption of a one-factor theory of learning to that of two basic learning processes—namely, problem-solving and conditioning. Psychogenic drives have a similar motivating and reinforcing influence in learning as do viscerogenic drives. In the last chapters of Part I, Mowrer discusses the applicability of his two-factor learning theory to the problems of insight, language, and conscience.

The second part of the book contains twelve chapters on a variety of topics that are of equal interest to psychologists, educators, and therapists. Among them are chapters on such diverse topics as enuresis, the life and work of Edgar Allan Poe, language, and the psychology of talking birds.

The author gives ample consideration to Freudian theory and to the similarities and differences between the Freudian theory and his own. He regards his views as an extension and a correction of the Freudian

system. He is of the opinion that the most important future advances in personality theory and psychotherapy will come from a mutual modification and blending of learning theory and psychoanalysis. He states that learning theory should be thought of as including "culture theory."

Mowrer considers neurosis, not as a learning excess, but as a learning deficit. He believes that a neurosis does not develop because of too severe demands of the superego, but, on the contrary, because the neurotic did not become sufficiently socialized and did not listen sufficiently to the demands of his conscience. According to the author, anxiety is produced by the repression of superego demands.

Because of the previously mentioned characteristics of the book, it cannot be adequately reviewed within a short space. It represents an impressive collection of important studies of personality dynamics with which any one interested in the field could profitably acquaint himself.

ALICE F. ANGYAL

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THE ORGANIZATION AND PATHOLOGY OF THOUGHT: SELECTED SOURCES. Translation and Commentary by David Rapaport. (Austin Riggs Foundation Monograph No. 1.) New York: Columbia University Press, 1951. 730 p.

The term "work book" has been preëmpted by the lower branches of our educational system; else it would be an excellent designation for this omnibus monograph. In the 730 pages that comprise this book, there are brought together—for the first time—representative examples of almost all important source materials on which to base a psychoanalytic theory of thinking. The practical value of this collection goes beyond the obvious usefulness of relevant aggregation, as most of the material was previously untranslated or is difficult of access. The organization and pathology of thought are dealt with by twenty different authors, representing different periods in the history of psychology and different points of view within psychodynamic theory. Properly to review a book of such richness and complexity would be to write another book; hence no attempt will be made to apprise the reader of its contents or to dissect its organization. Instead, we shall describe the manner of book it is and what it felt like to read it (at least to this reviewer).

The entire text is held together by footnotes so extensive that often they fill more space than does the text. This commentary is unlike any we have seen in other books. It combines the functions usually assigned to footnotes—to elucidate a point or to identify implications and references contained in the text—with active participation in the

argument proposed by the author, and with continuous discussion of the relationships between the ideas expressed in different segments of the book. The commentator does not hesitate to commend or to criticize, and from the footnotes there emerges a clear picture as to which authors are Dr. Rapaport's favorites. Thus, reading the book is not a passive experience of receiving information; it demands, instead, active participation in a heated discussion and requires of the reader that—for the moment at least—he side with the author or the commentator (or formulate his own view) on each emerging issue. In your reviewer's experience, the advantages of such a method far outweigh the inconvenience of skipping back and forth on the pages. We find it far easier to work through highly abstract material when—as in this book—it is embedded in the continuous process of hypothesis-making, hypothesis-discarding, and evaluation.

The footnotes accomplish yet another purpose, and do so with extraordinary skill: From the implications drawn, the criticisms leveled, and the issues chosen for high-lighting and special articulation, there emerges something like the ground-plan for a theory of thought unlike any one of those stated in the text, but related to them all. By the time the reader reaches the final chapter, he is prepared for the condensed and systematic presentation of a point of view. In the final chapter the commentator turns author and provides an integrated statement of much that is contained in the sources. We do not believe that the "conclusions" are fully intelligible until the text and footnotes have been read, (at least *we* failed to grasp the implications when we followed our habit and read the conclusions first).

It is in the nature of so encompassing a topic, and so vivid and partisan a presentation as we have tried to describe, that the reader's critical faculties will be aroused. Your reviewer is inclined to quarrel with many of Dr. Rapaport's statements. The difference from criticism of other books lies in the fact that one feels grateful for the opportunity to have formulated a problem that could not have been identified or seen in context without the explicit presentation in this book. Among the points that seem problematical to us the following may be mentioned:

1. Excellent translations of two previously untranslated and basic articles by Kurt Lewin are an outstanding contribution. Frequently throughout the (footnote) text, Dr. Rapaport restates an author's point in "Lewinian" terminology. The concepts of "quasi-need" and "quasi-tension system" play an important rôle, yet no mention is made of the fact that Lewin later discarded these concepts. He did so because it seemed to him that if a behavior sequence—however peripheral or transitory—conforms to the coördinating definitions for a "need" and a "system in tension," it should be conceptualized as such. The commentator is of course free to prefer an earlier Lewin-

ian formulation to a later one, but acknowledgment of the fact should have been made. Beyond this, some topological and vector psychological concepts (notably "satiation" and "valence") are incorrectly applied at times.

2. We were struck with the commentator's (negative) partiality toward Silberer's chapters on symbolic thinking. For instance, the author is criticized for maintaining an unwarranted dichotomy between "normal" (secondary-process) and "associative" (primary-process) modes of thought. Piaget, who ranks high with the commentator, carries this dichotomy much further and remains unchastised. Also, Silberer expresses the idea that when man tries to think about complex and insufficiently known content, his thought may have to take symbolic form—to find articulate, logical restatement after the subject matter has been mastered. The author's coolness toward this idea is puzzling, especially since the book under review furnishes an excellent example of this very process in the gradual transformation of psychoanalytic knowledge from thinking by analogies and with symbol-like concepts into "objective," logically ordered formulations.

3. It seems to us that the commentator's enthusiasm for the concept of the "conflict-free ego sphere" at times leads him to overstate the scope and implications of this concept. Thus, in discussing the relationship between affect and attention (apropos of Bleuler's observation that in schizophrenics one may observe an "affective transformation" of images which possess "special attention value") it is reasoned that attention cathexes are at the command of the conflict-free ego sphere, and hence are not related to affects. This is put in such a way as to characterize the autonomous ego almost as an "affect-free" sphere. Yet elsewhere we are warned against the equation of affect with drive.

Similarly, in the final chapter, the author-commentator enumerates certain "inborn structures" which partially determine the course of ego development. Apparently because these structures (*e.g.*, thresholds of tension tolerance, specific connections between drive and object, and so on) by definition do not arise from developmental conflict, it is reasoned that they form "the nucleus of the conflict-free ego sphere." This does not seem a compelling conclusion; in fact, it is more plausible to assume that such structural "givens" play a rôle in determining the intensity and specific modulation of instinctual vicissitudes, that they co-determine the development of specific defense structures, and *by this route* also serve to mold the characteristics of the autonomous ego sphere.

4. Lastly, the final chapter contains a masterly statement of the manner in which the author envisages the internalization of the conflict between id and outer world in the course of ego development. In the descriptive account of the functioning of the mature psyche,

this reviewer missed a discussion of the rôle of the superego with respect to the synthetic functions of the ego and to reality testing. The superego is mentioned only in the context of the increased capacity for socially shared (communicable) thought, acquired through introjection and identification.

With all of this we have as yet failed to convey our sense of the extraordinary value of this monumental contribution to psychological theory. Perhaps it can be hinted at by a description of the manifold ways in which this book contributes to an understanding of thought. In the first place, it brings together the *contents* of the thinking of many persons about thought. In the second place, the sequential arrangement of articles skillfully documents the *process* of increasingly articulate thinking on one topic (thought). In the third place, the running commentary provides the reader with an opportunity for the active *experience* of thinking. Thus it comes about that the subject matter read about is continually relevant to the on-going thought processes of the reflective reader.

Those familiar with scientific language in German and French know that it is well-nigh impossible to render the nuances of meaning in English. Dr. Rapaport and those who assisted with this task came closer to the ideal than have most translators. We were especially impressed with the poetic ingenuity with which idiomatic German schizophrenic language has been transmuted into English (*e.g.*, the letter of a schizophrenic patient quoted by Bleuler).

It is no reflection on the author, but rather an observation concerning the state of psychological theory, that it is possible to write an encompassing volume on thought without mention of its function in the larger context of social life. If this reviewer had her way, subsequent editions of this book would carry as a motto the following passage (reviewer's translation) from Hegel's *The Encyclopedia of the Philosophical Sciences*:

> "In the earlier days thinking was held to be a harmless activity. . . . People thought about God, about nature, and about the state, and all the while were of the opinion that thinking will lead to recognition of the truth. . . . As they continued to think, it developed that the most important conditions of life were (thereby) fatally altered. Thought robbed the positive of its power. . . . Thus the Greek philosophers of antiquity took a stand against the old religion and destroyed its concept. For this reason they were exiled and killed under the charge of overthrowing religion and the state. Thinking thus made itself felt in reality, and proved to be enormously effective. In this manner it came about that people were moved to pay attention to this power of thought."

SIBYLLE ESCALONA

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FIGHT AGAINST FEARS. By Lucy Freeman. New York: Crown Publishers, 1951. 332 p.

Several persons who have undergone the long and often tedious and trying therapeutic procedure of psychoanalysis have been tempted to record their experiences during the process. The latest to succumb to this urge is Miss Lucy Freeman, a journalist who is distinguished in the field of psychiatric and sociological reporting. That her book has been a success, at least from the publisher's point of view, is evidenced by the fact that it stayed on the best-seller list of non-fiction for many months.

The author's style is brisk, newsy, and familiar. In consonance with her professional activity, it is reportorial rather than descriptive or analytic and therein perhaps fails to convey a full picture of the intricacies inherent in a psychoanalysis, especially during the passage of those long periods of time where there is little movement in the analytic process. It is inevitable that in an account of so complicated an experience as psychoanalysis, the material selected by an author for the reader should be that which he desires to reveal because of his own estimate of its importance. In other words, the writer chooses, from a vast number of hours during which he has expressed unlimited conversations and associations and manifested reactions, those that have most pleased or humiliated him. Thus in this book one finds considerable repetition, but no one will question the author's desire frankly to portray within the limits of selectivity those situations which nourished the fears from which she suffered after graduation from college and which were responsible for many of her inadequacies and much of her unhappiness as she grew into a troubled young womanhood.

Captious psychoanalysts who reverently adhere to the classical procedure originally developed by Freud might be critical of the type of analysis that the author underwent. The attitude of the analyst to whom the patient refers familiarly as "John," as described by the author, is throughout extremely helpful, encouraging, and responsive to the author's transference. It seems indeed likely that only such an attitude could have induced the strong transference which became established between the analyst and his patient, and very likely this was necessary. To this reviewer it seems obvious that this particular patient, because of her excessive timidity, could not have responded to a person who avoided the friendly, almost intimate approach that "John" exhibited, also waving aside not only some cherished classically analytic technique, but many social formalities as well. Patiently and gently he sought to dispel his patient's agonizing fears and depressions by exposing to her those factors which nourished her fears and the compensatory need for achievement.

Generally when a patient has finished his analysis, memories of the whole procedure sink back into the inaccessible recesses of the mind from which the patient has little desire to retrieve them. One is likely to infer that when the need still exists to write about it, there is a necessity for compensation to expose directly or indirectly what has not been fully brought out in the course of the treatment. One might suspect that some such unconscious motive entered into the current narrative. Nevertheless, the simplicity and directness of Miss Freeman's book will impress many with the value of analysis where more erudite handling of the same theme would fail.

C. P. Oberndorf.

New York City.

Occupational Choice: An Approach to a General Theory. By Eli Ginzberg, Sol W. Ginsburg, Sidney Axelrad, and John L. Herma. New York: Columbia University Press, 1951. 271 p.

It is a characteristic of our culture that practically every one works; there are some drones, but they are a small minority. What each individual works at, what his job shall be, how well he is satisfied with his job, his stability in the job, and a host of similar questions can be answered only by a consideration of social, economic, and personal variables.

Of temporal primacy, and therefore important, among these variables is the individual's choice of a vocation. There is a respectable literature on the problem of vocational choice—the bibliography of the present volume cites nearly one hundred items directly related—but it presents evidence gathered in many ways and for many purposes without any systematic integration. On the other hand, certain systematists, particularly psychoanalysts, have proposed bases for occupational choices consistent with the theories, but with limited investigation of behavioral facts involved. In the course of an extensive study of the economics of human resources, the present authors came to recognize the importance of occupational choice, especially in adolescence, both for individual work satisfaction and for an adequate distribution of vocational skills in our society.

The investigation of the process of occupational choice reported in this volume is based upon intensive interviews with eight boys from each of eight educational stages—sixth, eighth, tenth, and twelfth grades, college freshmen and seniors, and first-year and advanced graduate students. All subjects were from the Horace Mann-Lincoln School and Columbia University. This admittedly select group provided the data for the basic analysis. Interviews with seventeen boys of lower socio-economic status, and of ten college women, gave data

which indicated that the developmental process of choice-making was not a necessary function of sex or socio-economic status. It is evident that with only 64 subjects in the eight main groups, and 27 in the two auxiliary groups, statistics would not be the method of choice for analysis. With careful logic, cogent insights, and restrained inference, the authors have secured from their data a tentative hypothesis of occupational choice that cannot be ignored in future consideration of the problem.

The general theory in the authors' formulation is:

> "First, occupational choice is a process which takes place over a minimum of six or seven years, and more typically, over ten years or more. Secondly, since each decision during adolescence is related to one's experience up to that point, and in turn has an influence on the future, the process of decision-making is basically irreversible. Finally, since occupational choice involves the balancing of a series of subjective elements with the opportunities and limitations of reality, the crystallization of occupational choice inevitably has the quality of a compromise."

The process of decision-making may be divided into three stages: fantasy choices made by children below approximately eleven years of age; tentative choices which characterize the adolescent's coming to grips with the problem of his future; and realistic choices which appear in late adolescence and early adulthood when the individual recognizes the realities of training requirements, job opportunities, and personal capacities as factors in his vocational decisions.

The major portion of the text is devoted to the development of this theory, the interview records being used for illustration. Findings from the two auxiliary groups give support to the theory. In two chapters the authors discuss the problems of emotional factors in choice, and the importance of the decision-making for work satisfaction. In neither of these does the investigation supply adequate answers. Both are areas for future research.

C. M. Louttit

University of Illinois

NOTES AND COMMENTS

A Manual on Community Planning for Psychiatric Clinics

A concise discussion of community planning for the establishment of psychiatric clinics, both child-guidance clinics and mental-health services for adults, has just been published by The National Association for Mental Health, under the title, *The Organization and Function of the Community Psychiatric Clinic.* This 104-page manual, by four authorities in the field—Dr. Milton E. Kirkpatrick, Dr. A. Z. Barhash, Miss Helen A. Sanders, and Miss Mary C. Bentley—takes up such frequently asked questions as: What is a psychiatric clinic? When is a community ready for a mental-health service? What groups should be included in plans for organization? What are the first steps after organization? What are the more likely sources of financial support? How much is needed to start a community clinic? Who should pay for mental-health services? What about supporting services? How does a clinic go about conducting a community survey?

The manual is intended primarily for community groups who are planning to establish psychiatric clinics, groups who are engaged in organizing such clinics, and clinic boards who are enlarging or revising their services. It will also help clinics to clarify their position in the community, to develop sounder administration, and to establish more constructive relationships between clinic staffs and clinic boards.

In addition, as a brief history of the child-guidance movement in the United States and a clear statement of the philosophy behind community mental-health services, it should be of great value to students of medicine, psychology, and social work.

The price of the manual is $1.00. Orders should be sent to The National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

Sixth Annual Clinical and Scientific Conference of The Association for Physical and Mental Rehabilitation

The Sixth Annual Clinical and Scientific Conference of The Association for Physical and Mental Rehabilitation, held in Milwaukee, July 7–12, represented an important innovation in the programing of medical meetings. In place of the usual formal papers, a different type of clinical presentation was introduced, consisting of symposia in which leaders and authorities in physical medicine, psychiatry, neurology, orthopedics, and industry were able to discuss specific

aspects of their various fields with one another and to answer practical queries from the audience. Needless to say, the interest in these panel-and-audience discussions was high, representing as they did a combined medical and industrial attack upon current problems of rehabilitation.

Formal papers were presented to complement the medical symposia, and daily demonstrations of corrective-therapy techniques were given in a specially organized correction-therapy clinic.

The theme of the conference, as stated on the program, was "Dynamic Medical Rehabilitation in the Treatment, Adjustment, and Employment of the Disabled." The extent of the field covered is indicated by the topics discussed at the various meetings: "Basic Concepts of Rehabilitation," "Rehabilitation of Hospitalized Mental Patients," "Employment of the Medically Handicapped," "Current Techniques in the Rehabilitation of the Speech Impaired," "To-day's Approach to the Care and Treatment of the Geriatric Patient," "Teamwork on a Rehabilitation Ward," "Educational Standards for Rehabilitation Personnel," "New Horizons of Correction Therapy," "Rehabilitation of the Amputee," "Orientation of the Blind," "Daily Care Activities in Medical Rehabilitation," and "Employment of the Physically Handicapped."

On one evening the Allen-Bradley Company, of Milwaukee, acted as host to the conference, and the scientific program was followed by a dance, refreshments, and conducted tours through the medical facilities of the company.

At the convention banquet, held on July 10, the key speaker, Mr. Phillip H. Reither, special agent of the Northwestern Mutual Life Insurance Company, gave a brilliant popular presentation of the over-all problems of rehabilitation in their impact upon the public.

The banquet was also the occasion of the presentation, to Dr. John Eisele Davis, Chief of Corrective Therapy of the Veterans Administration, of the John Eisele Davis Award, created by the Association of Physical and Mental Rehabilitation in honor of its founder.

A special award was presented to Dr. Arthur Abramson for his significant contribution to the field of rehabilitation, and a life membership in the Association of Physical and Mental Rehabilitation was given to Mr. George M. Reichle, program chairman, for his outstanding performance in organizing and developing the program of the conference.

A. P. A.'s *Mental Hospitals* Expands Its Service

Welcome news to institutional personnel who work directly with patients is the announcement that, beginning with its September issue, the American Psychiatric Association's periodical, *Mental Hospitals*,

introduces a new page addressed directly to them. Entitled, "The Patient Day By Day," this department is designed, in the words of the editor, for "the people who work daily with the patient, helping him bathe, dress, feed himself, play games, talk with fellow patients, draw or make things for himself or for the hospital. Just as the hospital ward with its vicinity is the substitute home of the mental patient . . . so are these people who live and work with him daily his substitute family in an intimate sense that nobody else on the hospital staff can become. These family figures vary, of course, in function, wisdom and authority . . . but each and every one of them helps to create the mood and atmosphere of the ward world.

"Contributions and suggestions for the page are invited from nurses, aides, attendants, and volunteers; from the therapists who help the patient to work and play; from those who induce him to eat —from all the people whom he sees daily and who are his companions and guides on the difficult road back to reality."

The National Association for Mental Health believes that this new page will make possible the regular sharing of experiences among all who comprise its audience, and that it holds real promise of assisting them toward much more effective job performance. Moreover, it is especially commended to the attention of former readers of *The Psychiatric Aide*, most of whom, since that publication's demise last March, have had no national organ to which they could turn for news of current activities related directly to their specific areas of work.

For full information as to how you can get this material regularly, consult your hospital superintendent; or write directly to Mrs. Pat Vosburgh, Chief, Editorial Department, A. P. A. Mental Hospital Service, 1785 Massachusetts Avenue N. W., Washington 6, D. C.

Hamilton Memorial Lecture and Award

The American Psychopathological Association has established the Samuel W. Hamilton Memorial Lecture and Award in commemoration of the contribution made by Dr. Hamilton, one of the founders of the association, to psychiatry, medicine, and sociology. The recipient of the award will be chosen each year by the Council of the American Psychopathological Association and presented with the Samuel W. Hamilton bronze medal after delivery of the Hamilton Lecture. Contributions received from members of the association and also from members of the American Psychiatric Association who participated as sponsors will perpetuate the award.

This year the first award was presented at the annual meeting of the American Psychopathological Association, June 7, in New York, to Dr. Clarence P. Oberndorf, clinical professor of psychiatry, Columbia

University, College of Physicians and Surgeons, New York, for his distinguished contribution to psychopathology. Dr. Oberndorf's lecture was entitled *Function in Psychiatry.*

Four Isaac Ray Lectures to be Given by Dr. Overholser

Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, Washington, D. C., will deliver a series of four "Isaac Ray Lectures" on "Psychiatry and the Law" at Harvard University Law and Medical Schools in November this year. Dr. Overholser was selected for the honor as the first winner of the American Psychiatric Association's "Isaac Ray Award," for his notable contributions to the field of legal problems connected with mental disorders.

The first two lectures of the series, on "The Substance of Psychiatry" and "Differences of Viewpoint," will be presented in the courtroom at Harvard Law School at 4 P.M. each day on November 13 and 14. The remaining two, on "The Mental Patient and the Hospital" and "The Psychiatrist as Witness," will be given at 5 P.M. each day on the 17th and 18th in Amphitheatre D at Harvard Medical School.

The Lamb Foundation

The death last June of Dr. Robert B. Lamb, of Harmon-on-the-Hudson, calls attention to the foundation that he established in 1942, as a result of his concern over the decline in mutually beneficial doctor-patient relationships. According to his observations, while scientific medicine and its teaching had gone forward steadily and brilliantly, the teaching of the art of dealing with the patient in the office, in the home, and in the hospital had by no means kept pace. As a means of remedying this situation, he established the Lamb Foundation, after much thought and consultation with friends and associates over a period of years.

Having endowed the foundation with sufficient funds for its immediate needs, Dr. Lamb advised the selection of three well-known medical schools for annual grants of funds to carry out its objectives. This program has been in effect for several years. The schools selected have coöperated wholeheartedly and their reports are most encouraging. Students also give encouraging indications that they are benefiting from the program and appreciate it.

Upon his death, Dr. Lamb bequeathed the greater part of his estate to the foundation, and although his own interests lay in the field of psychiatry, he provided that students in all branches of medicine should be recipients of its benefits.

Dr. E. H. Huntington, of Harmon-on-Hudson, is the president of the Lamb Foundation; Dr. Amos T. Baker, vice president; and Miss Phyllis M. Scott, secretary-treasurer.

Dr. C. F. Menninger Observes Ninetieth Birthday

Dr. Charles F. Menninger, founder of the Menninger Clinic and chairman of the Board of Trustees of The Menninger Foundation, observed his ninetieth birthday on July 11, in Topeka, Kansas.

Dr. Menninger was born in Tell City, Indiana, on July 11, 1862. After graduating from Central Normal College in Danville, Indiana, and serving as an instructor in science at Campbell College, Holton, Kansas, he enrolled in Hahnemann Medical College, then a homeopathic school in Chicago, Illinois. He was dissatisfied with his rudimentary medical education, however, and attended frequent postgraduate courses sponsored by medical institutions in various parts of the country. In 1906 he was awarded—as a result of his further studies—an M.D. degree (allopathic) by the Kansas Medical College of Washburn University. The same year he was named to the faculty of the college, where he served for a number of years as a lecturer in physiological chemistry, dietetics, and diseases of disturbed metabolism.

It was while attending a postgraduate institute at the Mayo Clinic in 1908 that Dr. Menninger conceived the idea of the Menninger Clinic, a father-and-son partnership which became a reality in 1919 and was reorganized as the non-profit Menninger Foundation in 1941.

Dr. Menninger is a former president of the Shawnee County Medical Society, and has served as president of the Topeka Board of Health. A specialist in internal medicine, he has had a particular interest in the subject of diabetes and other metabolic disturbances and has published a number of papers dealing with the subject.

Dr. Menninger is in good health and continues to be active in the affairs of the foundation. Only recently he journeyed to Chicago to preside at a meeting of the foundation's board and to address 300 members of the foundation on "Sidelights of Sixty Years of Medical Progress." Twice weekly at the foundation he instructs therapeutic classes in horticulture, mineralogy, and conchology. Two of his sons, Dr. Karl and Dr. William C. Menninger, are psychiatrists and leaders of the Menninger Foundation. A third son, Edwin Menninger, is publisher of the *Stuart* (Florida) *News*.

The Retarded Children

(Reprinted by permission from *Our Children's Voice*, a publication issued monthly by the Association for the Help of Retarded Children, New York City.)

Listen! We hear them calling through the night!
All of the faltering children of the earth—
Awake, asleep, we see them—seeking light—
Seeking a key—a meaning to their birth.

They are the lostlings—they are the least of these—
The brood of all the nations, creeds, and races.
Our dreams reëcho their unspoken pleas—
Reflect the image of their solemn faces.

And yet they have a wisdom all their own,
Precocious scholars of a grievous art—
So tolerant with us! And never prone
To scorn the world for its retarded heart.

Their eyes are fixed upon a distant star,
A glimmering hope that beams, as from above.
And we shall light their way, however far,
With all the burning power of our love!

E. G.

Fifty-four Years of Child Placement

Fifty-four years ago in August, the Child Placing and Adoption Committee of the State Charities Aid Association found the first home for one of its children. Since that time, according to a recent statement by Mrs. Artemus L. Gates, chairman of the committee, the committee has found homes for nearly 7,500 American children.

"While the children have come from nearly every national and racial heritage," said Mrs. Gates, "they have had two things in common: They were American children and they needed the love and security of parents and a happy home.

"Just last month the committee found homes not only for children of American stock, but for some of its newest citizens: an unusually intelligent little Syrian girl with a sparkling personality; a well-poised little Chinese boy with a fine sense of humor; and a pretty little girl of Czechoslovakian parentage who looks like the neighbor's child down the street.

"The committee, in seeking homes for its children, tries to replace as far as possible the natural protection they have lost. It does this by finding parents who have the sort of personality that harmonizes with the child's, so that they will feel 'at home' with each other.

"Since the beginning, the committee has worked to increase public understanding of the rights and need of homeless children, and has maintained that, given a normal family life, these children would grow up to do their share of the world's work.

"The record shows that the children have not let us down," Mrs. Gates continued, and she gave some examples, picked at random, of how they have turned out: A baby girl, abandoned at birth, is now one

of New York State's most gifted teachers of young children. A baby boy, of Southern European background, adopted by parents of similar background who made frequent trips with him to Europe, now holds a high position in the United States Government. One of the babies placed in 1899 by the committee was a Negro who has grown up to be a leader in her community and is now a proud grandmother.

The Child Placing and Adoption Committee, one of the oldest child-placing agencies in the country, is a non-sectarian group.

Center for Improving Group Procedures Established by Teachers College

To provide community agencies, public and private educational institutions and agencies, industrial and other organizations with consultation and educational services for more effective group procedures, Teachers College, Columbia University, has established the Center for Improving Group Procedures. Among the services available are group-leadership training programs, conference planning for group participation, staff-relations clinics, personnel-appraisal services, evaluation of supervisory practices, development of materials, and training and research programs designed to meet specific personnel needs.

The center is associated with the guidance department at the college, and is under the executive direction of Dr. Kenneth F. Herrold, associate professor of education at Teachers College, and social psychologist and consultant to business, public-health, nursing, and other organizations.

Three Seminars Announced by The Group Psychotherapy Institute

The Group Psychotherapy Institute, now in its third year, has announced the addition of three seminars to the curriculum of the 1952–1953 academic year. Each seminar will run for thirty consecutive two-hour sessions, beginning in October, 1952. The three seminars are: (1) a survey seminar on "Group Psychotherapy," in which a general outline of the various techniques employed in this form of psychotherapy will be discussed by seven different instructors, each giving about four sessions; (2) a seminar on "Activity Group Therapy With Children"; and (3) a seminar on "Analytic Group Psychotherapy."

Among the instructors in the first seminar will be Drs. Nathan W. Ackerman, Samuel B. Hadden, James J. Thorpe, and Aaron Stein. The second will be conducted by S. R. Slavson, Saul Scheidlinger,

Emanuel Hallowitz, and Leo Nagelberg; and the third, by Hyman Spotnitz, Helen Durkin, and others.

For further information write to The Group Psychotherapy Institute, 105 East 22nd Street, New York 10, N. Y.

A Seminar on Pastoral Psychology

Dr. R. J. Young, a psychiatrist on the staff of the Broome County Child Guidance Clinic, has been leading a group of clergymen of Binghamton in a seminar on pastoral psychology. This eleven-week program was initiated by the Binghamton Ministerial Association whose members felt they needed guidance in their pastoral work.

Meeting for one hour on Fridays, this seminar has learned about the principles of dynamic psychology largely through case materials brought in by the clergy themselves. Out of these informal discussions has come the realization not only of the need for clergy training in this field, but also of the close functional relationship that exists between the task of the psychiatrist and that of the clergyman. The conclusion has been reached that working together, at their respective levels of competence, the clergy and the psychiatrist can assist to-day's people to lead a creative, meaningful life.

1952 Reading Institute at Temple University

The Tenth Annual Reading Institute at Temple University has been announced for the week of February 2–6, 1953. The theme of the Institute will be "Curriculum Approach to Reading Instruction," and the aim will be to point up the need for an integrated program of reading in every phase of the child's school curriculum. The following topics will be discussed and demonstrated: (1) planning a reading program, (2) evaluating reading needs, (3) types of reading problem, (4) reading difficulties, (5) word recognition, (6) semantic analysis, (7) concept development, (8) developing reading skills, (9) directed reading activities, (10) reading readiness activities, (11) differentiated instruction, (12) reading materials, (13) organization of corrective classes, (14) developing critical thinking, (15) developing study skills, and (16) speed-reading techniques.

Supervised half-day sessions, differentiated for elementary, secondary, and college teachers, will provide direct experience with learners in the following activities: (1) the construction of an informal reading inventory, (2) teacher preparation of a directed reading activity, (3) estimation of reading and hearing comprehensive levels, (4) the identification of different types of reading disabilities, (5) the use of corrective and remedial techniques, (6) the evaluation of reading

readiness, (7) speed-reading techniques, and (8) the detection of visual problems.

Reading programs in public schools and colleges will be presented by delegates and evaluated by a selected staff during three half-day sessions. Delegates who desire to have their school programs evaluated should write in immediately for information on the preparation of their reports.

Advance registration is required. For a copy of the program and other information regarding the institute, write Emmett Albert Betts, Director, The Reading Clinic, Temple University, Broad and Montgomery Avenue, Philadelphia 22, Pennsylvania.

Ten Graduate Psychology Students Named to Study Under Army Program

Ten graduate students majoring in clinical psychology at colleges and universities in the United States have been selected to continue their education under the Senior Psychology Student Program sponsored by the Army Medical Service. To qualify for participation in the program, a student must need no more than two years to complete requirements for his Ph.D. degree in clinical psychology. The selected students will continue their studies while they receive the full pay and allowances of second lieutenants in the Medical Service Corps Reserve.

Upon completion of their academic work, graduates must apply for a regular army commission in the Medical Service Corps, and, if appointed, must agree to serve at least three years on active duty. Qualified applicants are appointed first lieutenants when they enter the regular army.

Since the inauguration of the Senior Psychology Student Program in 1949, fourteen graduate students have completed their studies under the program and subsequently received commissions in the army, serving as clinical psychologists and research psychologists.

Applications of graduate students and inquiries concerning the program should be addressed to The Surgeon General, Department of the Army, Main Navy Building, Washington 25, D. C., attention: Chief, Personnel Division.

The ten students first selected include four from the University of California at Los Angeles, and one each from Pennsylvania State College, New York University, Harvard University, the University of Illinois, Princeton University, and the University of Pittsburgh.

Announcements of Meetings

The National Association for Music Therapy will hold its Third Annual Meeting in Topeka, Kansas, October 30 and 31, and November 1, 1952, in the Hotel Kansan. Applications for active, associate, or student membership may be made to Mrs. H. Dierks, 5050 Oak Street, Kansas City 2, Missouri. Members of the medical or musical professions who are not members may attend meetings by paying a registration fee of $5.00.

The American Group Psychotherapy Association has announced that its Tenth Annual Conference will be held January 9 and 10, 1953, at the Henry Hudson Hotel, New York City.

One session will be devoted to a discussion of the "Applications of Group Psychotherapy to Related Fields" by several speakers. Areas to be covered will include education, government, and industry. Another session will deal with the theoretic aspects of group psychotherapy.

Six panel meetings will deal with group psychotherapy in (1) general hospitals, (2) child guidance, (3) private practice, (4) correctional institutions, (5) mental hospitals, and (6) related fields. Brief summaries of the panels will be presented at the concluding session.

Among the participants are: Dr. Kenneth Herrold, Dr. Henry P. Laughlin, Dr. Hyman Spotnitz, Dr. Aaron Stein, Dr. Daniel Lipshutz, Dr. James J. Thorpe, Dr. Daniel W. Hamilton, and Dr. Harris B. Peck.

Address inquiries to the American Group Psychotherapy Association, 228 East 19th Street, New York 3, New York.

The American Psychosomatic Society will hold its Tenth Annual Meeting at Chalfonte-Haddon Hall, in Atlantic City, on Saturday and Sunday, May 2 and 3, 1953.

The program committee would like to receive titles and abstracts of papers for consideration for the program by December 1, 1952. The time allotted for the reading of each paper will be twenty minutes. The committee is interested in investigations into the theory and practice of psychosomatic medicine as applied to adults and children in all the medical specialties, and in contributions in psychophysiology and ecology. One panel will be devoted to the adrenal cortex. Abstracts of contributions to this panel will be considered by the committee. Papers accepted for presentation at the meeting will be submitted to the editorial board of *Psychosomatic Medicine* for possible publication in the journal.

Material for consideration by the program committee should be

sent, in duplicate, to Dr. Sydney G. Margolin, Chairman, 551 Madison Avenue, New York 22, New York.

Recent Publications

A booklet on the physical, psychological, and mechanical aspects of rehabilitating the individual who has lost an arm has been issued by the Rehabilitation Center for the Disabled, of New York City, under the title *Arm Amputation.* Dr. John A. P. Millet, chief of the center's psychiatric services, contributes an introduction to the booklet and a short discussion of the psychological effects of amputation. The importance of taking psychological factors into account in the rehabilitation of the amputee is emphasized also by Dr. Frederic G. Elton, director of the center, in his paper, *Arm Amputation.*

The remainder of the booklet is given up to a training manual by N. P. Smith, illustrated with photographs. It takes up such subjects as muscle exercises; mechanisms for developing strength and control; stump exercise; dexterity-developing activities; developing function in an injured hand; training in the use of the prothesis, or artificial part, as a working tool; left-hand writing; and one-hand typewriting.

The book may be obtained without charge by writing to the Rehabilitation Center for the Handicapped, 28 East 21st Street, New York 10, N. Y.

First of its kind is a booklet, *Psychological Problems of Cerebral Palsy,* just published by the National Society for Crippled Children and Adults, the Easter Seal Society.

The proceedings of the first symposium ever held to consider exclusively the psychological aspects of cerebral palsy, the booklet brings together the important papers of outstanding psychologists presented at that meeting. More than 500 of the nation's leading psychologists attended the symposium, which was held in Chicago under the joint sponsorship of the Division of School Psychologists of the American Psychological Association and the National Society for Crippled Children and Adults.

Literature in this specialized field has been very limited, according to Lawrence J. Linck, the society's executive director. This booklet will serve as a valuable addition to the authoritative material on these important problems.

Copies of the booklet can be purchased at $1.25 apiece from the National Society for Crippled Children and Adults, 11 South La Salle Street, Chicago 3, Illinois.

The Family Service Association of America has issued in pamphlet form seven articles on various phases of adoption selected from 1947–

1952 issues of *Social Casework*. *Adoption Principles and Services* is the title of the pamphlet, and the seven articles are: "What Do We Seek in Adoptive Parents?" by Florence G. Brown; "Rorschach Tests as a Diagnostic Tool in Adoption Studies," by Frieda M. Kuhlmann and Helen P. Robinson; "Casework Considerations in Rejecting the Adoption Application," by Ruth Michaels; "Who Are the Children Available for Adoption?" by Helen W. Hallinan; "Placement for Adoption—A Total Separation?" by Emily Mitchell Wires; "Financial Assistance in an Adoption Agency," by Catherine Donnell; and "Special Problems in Casework with Adoptive Parents," by Ruth Michaels.

The pamphlet can be obtained from the Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. Single copies, 85 cents; 10 copies, $7.65.

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